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Lessons Learned

from

Research, Evaluation and Analysis Studies

of the

Private Sector Family Planning Project

by

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The opinions, conclusions and recommendations included in the summaries are those of the study authors. The "lessons learned" and "issues" that need to be addressed are drawn from those summaries and other project experience, but are my responsibility. They do not necessarily reflect the views of the authors of the studies, BKKBN, IDI, IBI, ISFI, PKMI or USAID.

This is the final product of a very important and productive project that I was honored to be a part of over the past five and a half years. I sincerely hope that it will be useful to BKKBN, USAID and others in future planning.

Preface

This report includes lessons learned from and summaries of 54 studies conducted under the Private Sector Family Planning project (PSFP) between mid-1992 and early 1996. The report has been prepared in both Indonesian and English to make it more readily accessible to those who work within the program and to those who provide external technical assistance to it.

Project Overview

The PSFP project ran from October 1990 through June 1996. Funded directly by the USAID mission in Jakarta, the project was the centerpiece of AID population assistance in Indonesia during the period. The objective of the US $28 million project was to increase the use of private sector family planning providers and contraceptives, especially longer-term contraceptives (IUDs, implants and voluntary sterilization). Most activities were concentrated in the eight largest provinces: West Java, Central Java, East Java, Bali, North Sumatera, South Sumatera, Lampung and South Sulawesi. Some activities, especially social marketing of contraceptives and support for sterilization, were nationwide.

The project consisted of four inter-related components: 1) social marketing of private sector contraceptives in urban areas: 2) community-based distribution of contraceptive services and products in rural areas; 3) private sector development (especially private midwives; and doctors and pharmacies); and 4) promotion of long-term contraceptive methods, especially VS, but also IUDs and implants. These activities are described in more detail in the Lessons Learned section.

The PSFP project was under the direction of BKKBN (the Indonesian National Family Planning Coordinating Board), which managed local BKKBN costs and provided grants to the doctor's (IDI), midwife's (IBI) and pharmacist's (ISFI) associations, as well as to the local voluntary sterilization association (PKMI) to carry out their family planning activities. University Research Corporation (URC) and its subcontractor, The Futures Group (TFG) provided technical and administrative assistance to these groups as well as to BKKBN through a Project Support Group (PSG) located in BKKBN's Bureau of Planning. The contract also funded the Blue Circle Products Campaign, which was managed independently by a local marketing organization named Unggul Wirya Adicitra (UWA).

More information about the project, including its accomplishments, can be found in the summaries. See, in particular, the PSFP Final Report and the Final Evaluation of the PSFP project.

Purpose of this Report

Although it was not designed as a research project, a large number of studies were conducted over the life of the project. Most of these were conducted for internal purposes and were not widely distributed. Many were in English and were not easily accessible to Indonesian speakers, and vice versa. Most of the studies did not include summaries.

With the project coming to an end, project and USAID staff realized that many of these reports were likely to be lost and with them their findings and recommendations. In addition, with the disbanding of the Project Support Group (PSG), and the turnover of staff

at BKKBN and USAID, it was clear that the "institutional memory" of lessons learned from these studies would also be lost.

A last minute extension of the PSFP project at the end of December 1995 provided an opportunity for the PSG to rectify this situation. A plan was proposed and approved to collect, abstract, translate and disseminate the summaries and to extract lessons learned from them.

Organization of the Report

The report begins with Lessons Learned, starting with a few general lessons. The remaining lessons are organized by project component, i.e., social marketing, community-based distribution, private sector development, and long-term methods. That is followed by the 54 study summaries, also organized by component. There is also a general category for studies that cover more than one component. The Appendixes include an alphabetical bibliography for reference and an index of key words to help readers identify studies that deal with topics of specific interest, such as JPKM and quality assurance.

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Acronyms and Abbreviations

Organizations

ASEAN	Association of Southeast Asian Nations
AVSC	Association for Voluntary Surgical Contraception
BIPIM	Bureau of Community Institutional Development, BKKBN
BIREN	Bureau of Planning, BKKBN
BISEP	Bureau of Contraception, BKKBN
BKKBN	National Family Planning Coordinating Board
CA	Cooperating Agency (USAID grantee/contractor)
Depkes	Department of Health
IBI	Indonesian Midwife's Association
IDI	Indonesian Medical Association
IDHS	Indonesian Demographic and Health Survey
IEC	Information, Education and Communication
IISRF	Identification-Information-Screening-Referral-Follow-up system
IPADI	Indonesian Demographers Association
ISFI	Indonesian Pharmacists Association
IUD	Intrauterine Device
JPKM	Guaranteed Community Health Services
LPPKM	Institute for Mass Communication Research and Development
MIS	Management Information System
NGO	Non-Governmental Organization
NRC	National Resource Center
PENMOT	Bureau of Information and Motivation, BKKBN
PKMI	Indonesian Association of Secure Contraception
POGI	Indonesian Association of Obstetricians and Gynecologists
PSFP	Private Sector Family Planning project
PSG	Project Support Group (PSFP)
PUBIO	Biomedical Research and Training Center
SDES	Service Delivery Expansion Support project
SRI	Survey Research Indonesia
TFG	The Futures Group
URC	University Research Corporation
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
UWA	Unggul Wirya Adicitra (marketing management organization)

Other Terms

Bidan di desa	Village midwife
CBD	Community-based distribution
CYP	Couple-years of contraception
COPE	Client Oriented Provider Efficient (services)
Desa	Village
ELCO	Eligible Couple
FP	Family Planning
IEC	Information, Education and Communication
KB	FP (family planning)
Kabupaten	Regency (next administrative level under the province)

Kecamatan	Subdistrict (next administrative level under the regency)
Kotamadya	Municipality
LTM	Long-term methods
MKET	Most effective methods
NRC	National Resource Center
PAKBD	Village Family Planning Contraceptive Post
PLKB	Family Planning Field Worker
PPKBD	Village Family Planning Motivator
PIL	Project Implementation Letter
QA	Quality Assurance
QOC	Quality of care
RAM	Repair and Maintenance (center)
Rp	Rupiah
RT	*Rukun Tetangga* (Neighborhood association, lowest administrative level)
RW	*Rukun Warga* (next lowest administrative level, made up of several RT)
TOT	Training of Trainers
VS	Voluntary Sterilization
XQA	External Quality Assurance

LESSONS LEARNED

Findings, conclusions, recommendations and lessons learned are terms that are often used interchangeably. In this report the term "lessons learned" refers to what we have learned about a cause-effect relationship based on experience gained in the project. For example, on the positive side we have learned that a large proportion of married couples are willing and able to pay for commercial contraceptives, as long as the products are of high quality, reasonably priced, accessible and recommended by a trusted provider. We have also learned some negative lessons. For example, without a massive campaign to promote VS the number of acceptors will not increase much beyond what it is now. Concentrating on improving the supply side of VS (more clinics, more trained personnel, more equipment, etc.) are not enough.

These lessons, positive and negative, are important for policy making, in particular. By learning from our experiences and applying that new knowledge in planning and policy development, we can improve the effectiveness of our interventions as well as reduce costs.

A number of "issues" are also identified in this section. "Issues" are defined as problems that need to be addressed. In general, either the cause of the problem is unknown and more research is needed to find the cause; or the cause is known but the solution to the problem has not yet been developed; or the solution is known, but for one reason or another it has not been implemented.

It is important to remember that this report is limited to studies and lessons learned under the PSFP project. A number of other organizations conducted studies during this period and neither those studies nor the lessons that emerged from them are included in this report.

1. GENERAL

The overall objective of the PSFP project was to improve health and reduce fertility by: 1) increasing contraceptive prevalence; 2) increasing the use of private sector providers and contraceptives; 3) increasing the quality of services and care; and 4) increasing the use of longer-term contraceptive methods.

The project was successful in most of these areas. Fertility declined from 3.02 in 1991 to 2.86 at the end of 1994. Contraceptive prevalence increased from 49.7 to 54.7 percent over the same period. Private sector use increased from 22.1 to 28.1 percent; but long-term method use remained about the same: 19.7 to 19.0 percent from 1991 to 1994. Some progress, although unquantified, was made in improving the quality of services. See Studies # 6-8, in particular for details. The general lessons that can be learned from the overall project experience are listed below.

Lessons Learned

1. **A comprehensive and coordinated program can have an impact.** The project components were operating independently of one another initially, but were brought together to focus on the eight largest provinces. Coordination among the components was also promoted so that they complemented one another. For example, the Blue Circle program opened up the private sector in the urban areas, and worked with

private doctors, midwives and pharmacists who were being trained under another component. The key lesson to be learned here is that coordination and cooperation among program components can lead to a synergistic outcome that is greater than the sum of the outcomes of the individual components.

2. **Political factors can limit or aid impact.** Political support has always been an important element in the success of the Indonesian program. "Political commitment" is usually the first activity undertaken in a new program strategy, and this was true in all of the PSFP components. But political resistance or opposition are equally important, and cannot be ignored. Some program initiatives failed because of the absence of political support, and in some cases nothing could be done to overcome that obstacle. Thus, the key lesson to be learned here is that one may have to postpone an initiative until the political climate changes and is supportive. Sometimes one may have to drop an initiative entirely when it becomes clear that the political climate is not going to change in the foreseeable future.

3. **Many improvements are still possible.** All of the initiatives that were implemented can be improved. Training, quality of services, IEC, interpersonal communications, monitoring and supervision, research, counseling, planning, and many other areas can be done more simply, more effectively, more quickly, and at much less cost. Some of the studies identify ways that this could be done. Some recommendations have been taken up and acted upon, but many have not. There are a number of reasons for this: lack of time, lack of interest, lack of knowledge of the suggestions, are a few. The key lesson to be learned here is that follow-up is essential if the progress made in a project is to be maintained and built upon.

Issues

1. **Follow-up is needed.** There is no mechanism to follow-up on all of the lessons learned from the project, to replicate successful initiatives, to revise or close unsuccessful activities, to complete unfinished studies, or to resolve issues that have been identified. BKKBN and USAID, in particular, need to develop and implement a mechanism to do this.

2. Social Marketing

The objective of this component was to increase private sector sales of (commercial) Blue Circle contraceptives (IUD, pill, injectable, condom) in urban areas through mass media advertising (TV, radio, print), promotions, public relations, improved distribution, market research and operations research. These activities were managed by a marketing firm contracted to work with four pharmaceutical companies. The hope was that by the end of the project, enough demand would have been created so that the pharmaceutical companies would continue to market these contraceptives on their own.

At the same time, BKKBN was promoting the use of private sector providers (doctors, midwives and pharmacies). Midway through the project (1992-93) BKKBN also introduced another line of private sector contraceptives, known as Gold Circle.

The Blue Circle campaign was a huge success. Market research showed that ever use of Blue Circle was 39 percent, and current use was 28 percent by the end of 1994. The image of Blue Circle was of a high quality, affordable product that is recommended by providers

and suitable for users. Although sales increased steadily through 1992, they declined somewhat thereafter due to stockouts of IUDs and condoms, competition from generic brands of injectables, and confusion about the difference between Blue and Gold Circle products.

The most successful product was the Blue Circle pill, whose sales continue to increase. Overall commercial sales, although competitive with Blue Circle, have increased. Blue Circle was effective in demonstrating that there is a market for the private sector. The 1994 IDHS showed that private sector use increased to 28 percent, from 22 percent in 1991.

Sales could be even higher in the future if stockouts and BKKBN competition can be avoided. A significant challenge that remains is to find a way to open up the private sector market in rural areas.

Lessons Learned

1. **The private sector is viable.** Blue Circle was clearly a major success in its prime urban markets. The lesson to be learned here is that with a modest amount of encouragement and support, the private sector can and will respond to market opportunities. The private sector is now well-established and should continue to grow without further subsidization.

2. **The Blue Circle Campaign strategy worked.** The strategy (see Study #11 for details) was to recruit pharmaceutical companies to produce, package and distribute Blue Circle brand contraceptives through their own outlets and distributors at a reduced retail price in return for an exclusive license to use the Blue Circle logo and 4-5 years of marketing support (market research, advertising, public relations and government promotion). By the end of the project demand was expected to be sufficiently high to encourage the companies to continue marketing these products to the public without further subsidies. Other companies were expected to enter the market as they witnessed the growth of Blue Circle. Increased competition would help to keep prices down as well as expand choice of methods and broaden availability. This is exactly what happened.

3. **Market segmentation works.** The project clearly differentiated between urban couples who could afford to pay for Blue Circle contraceptives and rural couples who could not. The project was very successful in reaching, and selling its products to, its target population. Later experience in CBD also showed that the rural market could also be segmented.

4. **Demand for quality contraceptives is high.** We also learned that there are more people ready and willing to pay for contraceptives than originally thought. The project targeted the B, C, and D classes, but there was also significant demand from A and E classes. The CBD component showed that significant proportions of couples were willing to pay to have contraceptives delivered to their homes, and a large, untapped market already exists if ways can be found to bring commercial contraceptives to the villages.

5. **Distribution by the private sector to rural areas is hampered by distance, limited buying power, and government competition.** Although there are people in most

rural areas who are willing and able to buy commercial contraceptives, there aren't as many as in urban areas, and they are more difficult to reach. This is made worse by the government's practice of distributing free contraceptives to field workers, providers and acceptors on a massive scale.

6. **Mass media advertising produces results.** The Blue Circle "Ya-Ya-Ya" campaign is one of the most successful in recent Indonesian advertising experience. The slogan, the jingle and the message are almost universally recognized throughout Indonesia, even in rural areas, which was not a target area. Blue Circle products now have a more positive image than any other line of contraceptives, including that of the government.

7. **Constant public relations campaigning also pays off.** The Indonesian program is well-known within and outside of Indonesia for its mastery of the media and its ability to keep bombarding the public and opinion leaders alike with positive messages about family planning that people remember. The strategy to include everyone in the Family Planning Movement (teachers, insurance companies, midwives, civil servants, the military, etc.) involves a lot of effort, but it continues to pay remarkable dividends. A special VS PR campaign also demonstrated that opinion leaders (from government, business, religion, medicine) could be recruited to openly discuss this controversial subject and would endorse the method as a result. It also showed that by giving the press a small amount of orientation on VS, coverage and accuracy of reporting would increase dramatically.

8. **VS cannot become a significant method without a strong social marketing campaign.** On the negative side, it is now very clear that the government's exclusion of VS from the national program and it's inability and/or unwillingness to promote the method openly and aggressively has been the major reason that VS remains a minor method.

9. **Market research helps advertising and policy-making.** Surveys, focus groups, retail audits, provider interviews, etc., all play an important role in helping to shape an advertising campaign so that the right audience receives the right message in the right way and at the right time. The contrast with IEC campaigns that are not based on market research provides ample evidence of the difference in impact. In addition, research results have an important effect over time on policy-making. BKKBN policy makers paid attention to these results, which led to internal dialog and, little-by-little, changes in government policies toward the private sector.

10. **The major constraint to the growth of the private sector is government purchasing and distribution of contraceptives to those who can afford to pay for them.** The "bottom line" for private manufacturers is sales and profit. BKKBN's perspective is one of "public service," and these two perspectives are not always compatible. Until the government is willing to stop buying and distributing contraceptives to those who can afford to buy them, the private sector will be unwilling and largely unable to penetrate these markets.

11. **Quasi-government pharmaceutical companies and manufacturers are not as effective as private ones.** The Blue Circle pharmaceutical companies were made up of two private companies, one private distributor that was dependent on a state-owned factory for its product, and a quasi-government company. The private distributor had no sales for almost two years because the state-owned factory stopped producing its

contraceptives. The quasi-government company underproduced its contraceptives, which led to a drop in sales, and put very little effort into marketing, in contrast with the two private companies. There was also no way to discipline the state companies because of the politics of the situation.

Issues

1. **Market segmentation in rural areas.** There is a need to develop and test effective ways to segment the market in villages where a portion of the populace is willing and able to purchase commercial contraceptives, but where a significant portion is not. The CBD Operations Research projects had some success in this area (see Studies # 12-17, also # 28).

2. **Competition from BKKBN** is one of the major constraints on private sector growth. There is a need to find a way to encourage BKKBN to reduce: 1) purchases of contraceptives (to allow the private sector to enter the market); and 2) "leakage" of government contraceptives to private providers (which reduces demand for private sector products).

3. Community Based Distribution

CBD began in Indonesia in 1979 and has been a very successful government program. The objective of the PSFP project was to increase the use of private sector providers and contraceptives in rural areas. Field workers and volunteers were trained in three key interventions: 1) home delivery of pills and condoms for a small fee, the proceeds to be used to offset worker transportation costs and to pay transportation costs of acceptors who experience side-effects and wish to switch to a clinical method; 2) payment of monthly dues by members of acceptor groups into a community fund to pay for transportation costs of cadres and acceptors; 3) sales of Blue Circle condoms and pills by PPKBDs (community-based workers); and 4) promotion of the use of private sector services by making referrals.

USAID provided two years of funding in each of the eight project provinces to pay for training of community leaders, field workers, volunteers and others. Close to 300,000 were trained. Funds also paid for the development of IEC materials, new contraceptive distribution systems, and operations research, mostly on ways to overcome barriers to the use of village midwives.

Separate evaluations were conducted in each of the eight provinces (see Studies # 18-27). The data show that the field workers and volunteers were quite active in carrying out CBD activities. Over 40 percent of the eligible women interviewed said that a family planning field worker had recommended them to a private sector doctor or midwife. Over 30 percent said they had been visited in their home by a field worker who offered to bring contraceptives to them at home. And over half of those accepted the offer. And of that group, almost two-thirds paid for the service. Over one-quarter of the respondents said that a community fund for family planning had been established, and 85 percent of those said that they were members of the fund.

Three out of four of the target population (78 percent) had seen the Blue Circle logo, and almost the same percentage (72 percent) had heard of *KB Mandiri.* About 3/4 of those knew what it meant (to be self-sufficient, pay for family planning yourself). Most important, almost 29 percent of the target population was full *mandiri* (paid the full cost),

and another 43 percent were partial *mandiri*. That is, a combined 72 percent of the population paid something. The PSFP project objective was to reach 40 percent by the end of 1994.

The CBD program was very effective in increasing *KB Mandiri* in rural areas. But it was less successful in areas that did not have easy access to private services and contraceptives. A significant challenge that remains is to find ways to segment the rural market so that those who are willing and able to pay for family planning can do so, and those who are poor still have access to free or subsidized services.

Lessons Learned

1. **More rural couples than thought are willing and able to pay for their contraceptives.** The CBD program was very effective in increasing *KB Mandiri* in rural areas. Combined full and partial *mandiri* is almost 27 percentage points higher than the project objective. Thus, it seems clear that many people are able and willing to pay for their family planning services, and that CBD is a very effective intervention for making it possible for large numbers of people to do that.

2. **The rural market appears to be self-segmented**, apparently into three groups: about 30 percent who pay the full price; 40 percent who pay part of the price; and 30 percent who are not paying anything. It is important to keep in mind that those who are paying are not necessarily paying for commercial contraceptives. The CBD workers delivered government contraceptives for a fee, for example. Thus, there is a viable market there for the private sector to penetrate.

3. **The poor still need to taken care of by the government.** Despite the success of the CBD program, it is also clear that a significant proportion of eligible couples cannot afford to pay for family planning services or contraceptives. Thus, the government still needs to take care of this segment of the population.

4. **The presence of a private provider is critical to KB Mandiri.** Those areas that did not have access to a private sector doctor or midwife were at a much greater disadvantage in becoming *mandiri* than those that had such access. That is because injectables, IUDs and implants can only be provided by trained doctors and midwives. Since these methods are used by 30-50 percent of acceptors, that means that the CBD program is of little use to those acceptors unless they have access to private providers.

5. **Village Midwives Can be Enticed to Stay in Their Villages.** Several OR studies (see Studies # 12-17) demonstrated that several things can be done to make it more attractive for village midwives to live in and remain in their assigned villages. These are: 1) community support (including support from community leaders); 2) active promotion of and referrals to the village midwife by the local field workers and FP volunteers; 3) construction or assignment of a work area/home for the midwife; and 4) a reliable contraceptive, medicine and supply system. Enrollment in and support from the nearest IBI chapter also seems to help by providing peer support and advice.

6. **A reliable contraceptive supply system is critical as well.** It is also clear that even if there is a qualified midwife in the area, there may not be a viable system for providing her with the contraceptive supplies that she needs. This limitation seems to be directly correlated with such factors as the number of people in the community who are willing

and able to pay for services, the distance from the nearest pharmacy or distributor, and the degree to which the community uses the midwife's services. As the CBD evaluation showed, "the system is to some extent still dependent on the government (BKKBN)." See Study # 27.

7. **Rural distribution by the private sector is difficult.** Despite numerous efforts to get private sector to distribute contraceptives in rural areas, this remains a significant problem. Private sector pharmaceutical companies and distributors are in business to make a profit, and they cannot afford to distribute contraceptives to areas where there is not profit potential. This means that even if there are people in a village who are willing and able to pay for private contraceptives, they may not be a large enough group to make it worthwhile for the private distributor to do so. Thus, some "critical mass" of customers must be reached in rural and remote areas before a private company will be willing to take the risk of providing contraceptives.

8. **The "Referral Pharmacy/Village Contraceptive Post" concept is attractive but still needs development.** Evaluations of pilot tests of this concept have consistently shown problems in distribution, management, funds, availability of contraceptives at the village level, and so forth. The latest evaluation of some of the best of these Referral Pharmacies in one of the best provinces found similar problems (see Study # 28).

9. **Community Funds Work in Some Areas, Not in Others** (see Studies # 12-27). A more in-depth study/analysis of these funds may be needed. The CBD evaluations showed that some were very successful, others moderately so, some barely worked at all, and quite a few communities never set them up. In general, it seems that the funds work best where there is an adequate base of people with enough income to contribute to the fund, a cohesive community, strong leadership of the fund, flexible policies regarding use of the fund, and good record keeping and reporting.

10. **BKKBN has a well-developed capability to conduct CBD training on a massive scale.** The project demonstrated that some 300,000 community workers, leaders and others could be trained in a standardized CBD course with minimal input from technical advisors. Thus, nationwide replication of this or a modified CBD training program could easily be undertaken by BKKBN without further outside assistance. However, content, methods, follow-up and impact have often been criticized for being more ceremonial and motivational than substantive and competency-based (see Study # 1 and 27). BKKBN has the capability to address this deficiency and should be encouraged to do so.

Issues

1. **Private Sector Distribution**. This remains a major problem. As mentioned in the Social Marketing section, market segmentation and reduction of competition from BKKBN are key constraints. But more important in many areas is the willingness and ability of people to pay for commercial contraceptives. The government needs to develop a system (such as KS) for segmenting the market and then turning selected communities over to the private sector.

2. **Continuation/Expansion of CBD.** Given the positive results of the CBD component, the testimonials of the provincial BKKBN staff, and the general opinion within BKKBN that CBD can and should be continued and expanded, what should happen next? So far

there is no commitment from BKKBN Central to either continue or expand the program. If it is to be continued, some significant revisions need to be made in several areas, including training and community funds. This could be very expensive. Does BKKBN have the resources and commitment to do this?

4. PRIVATE SECTOR DEVELOPMENT

BKKBN began working with private professional associations around 1986, when it began the *KB Mandiri* campaign. The most important of these are IBI (the midwives), IDI (physicians), and ISFI (pharmacists). The PSFP project's objective was to increase the supply of trained private sector providers: 2,500 doctors, 2,500 midwives and 2,000 pharmacists. Over 9,000 were trained by the project, over half of which were midwives.

The most successful and responsive portion of this component was IBI. In addition to training 5,428 private sector midwives in clinical and non-clinical skills, a very successful "peer review" program was developed, tested, and implemented in four provinces (see Studies # 33 and 34). This program, which is now being expanded to other provinces, is designed to improve the quality of care provided by private midwives and to strengthen the training, fund-raising and continuing education capabilities of local IBI chapters.

IDI's training program was directed at general practice physicians. An assessment conducted about halfway through the project found that this was not the appropriate target group and the training was halted (see Study # 29).

Later it was decided to explore the feasibility of setting up comprehensive health clinics under the JPKM (managed care) program of the Department of Health. This was attractive because the JPKM program includes family planning as one of its basic services - at no extra charge to members and their dependents. For a variety of reasons, the development of this pilot project was exceptionally slow. The first three IDI clinics were opened in December 1995, almost two years after it was decided to go ahead with this pilot. Thus, there is very little that can be reported at this time, but an evaluation conducted in December concluded that the concept is a promising one (see studies # 31 and 32).

ISFI's role in the project was relatively minor, especially in comparison with IBI and IDI. Although 2,000 pharmacists went through an orientation program, it appears that the more appropriate group would have been the assistant pharmacists, who manage the pharmacies on a day-to-day basis. ISFI also set up "Referral Pharmacies" which are supposed to support "Village Family Planning Posts." The idea is to improve the availability of private sector contraceptives in rural areas. Two assessments in 1992 and 1993 showed the system had serious limitations. In 1995 ISFI conducted an evaluation in East Java that showed that the concept still has serious limitations (see Study # 28).

Lessons Learned

The key lessons learned are that the midwives are the most important private sector providers, and should receive additional support. Private sector GPs and pharmacists are not key providers of family planning services. However, the managed care clinics and Referral Pharmacies are worth examining carefully, and supporting if they are effective.

Midwives

1. **Midwives have become the most responsive and most important of the private sector providers.** The 1994 IDHS showed that 16.2 percent of family planning users went to private midwives for their services. That is more than the total of all other private sources combined (see Study # 2).

2. **IBI members respond enthusiastically to high quality training and professional development initiatives that meet their needs.** Their acceptance of the medical training, the non-medical training, and the peer review system was very positive.

3. **IBI's Peer Review system was effective in improving quality of care.** The most important factor was the immediate feedback provided by the reviewer to the midwife. A substudy validated that midwives could be trained to make accurate observations of the quality of family planning service provided by other midwives. Another substudy showed that self-assessment, using the same Peer Review checklists, was also effective (see Study #34). This simple system could possibly overcome some of the limitations found in the PKMI external QA system (see Study # 44).

4. **The Peer Review system works very well as a tool for organizational development as much as it does for quality improvement.** That is because it generates a set of complementing activities (fund-raising, training of trainers, and continuing education) that make the chapter stronger and membership increase (see Studies # 33 and 34).

5. **The Bidan di Desa is going to be the key provider of family planning services in rural areas.** Many of these midwives need support, advice, and training. Theoretically, IBI could provide this assistance. And it is probably the only organization that could.

6. **The OR projects showed that the Bidan di Desa can be enticed to remain in her assigned village** (see CBD Lessons Learned, No. 5 and Studies # 12-17).

Doctors

1. **OB/GYN specialist play a key role.** The role of the doctor is very important to the National Family Planning Movement, especially the OB/GYN specialists, not just for services, but also as trainers of others in contraceptive services.

2. **General Practitioners (GP) are important in the public, but not the private sector.** The GPs in the government health centers and hospitals see large numbers of family planning clients. But in the private sector, the demand for family planning services from general practitioners is quite low. The people generally select specialist physicians or midwives for their family planning services (see Study # 29).

3. **GPs could have a key role in JPKM clinics.** In these comprehensive clinics the private practice GP has a chance to play a much greater role than in solo practice The JPKM clinics will be staffed with teams of nurses, midwives and specialists, as well as equipment and medications that will make it easier and more practical for the GP to become involved in the provision of routine (and in some cases, clinical) family planning services. JPKM has two other great advantages from the perspective of the PSFP Project: first, it includes family planning as one of the basic services, so that it will be available to all participants; and second, JPKM is a private sector program, which

means that all participants will not only have access to all contraceptives at no additional cost, but will be full *Mandiri* at the same time (see Studies # 31 and 32).

Pharmacists

1. **Pharmacists are not necessarily the most appropriate training targets for family planning.** Assistant pharmacists may be more appropriate, since they are the day-to-day managers of the pharmacies, and more likely to have contact with customers and to be responsible for purchasing of drugs, medicines and contraceptives.

2. **The Referral Pharmacy concept is an appealing one, but it appears to be one that has serious operational problems.** The lack of conclusive evidence that it works raises questions about the viability of the design and/or the implementation. Those questions will not be answered until a careful, objective evaluation is conducted. The recently completed study in East Java examined some of the best Referral Pharmacies and still found serious operational problems (see Study # 28).

Issues

1. **IBI needs to be given priority support.** The PSFP project was clearly of great value to IBI. The organization, which has often been characterized as "weak," responded positively to the challenge provided by the project. Toward the end of the project, IBI prepared a five-year plan to replicate the training and peer review activities in all IBI chapters throughout the country. But support for implementing that plan has been slow in coming. Action needs to be taken to help IBI get the support it needs to carry out this plan and to incorporate the Village Midwives into their professional development program.

2. **Private comprehensive JPKM health clinics need to be developed.** Specialized private family planning clinics have not proven to be viable. But comprehensive health clinics can attract a wide variety of clients. That does not assure that they will provide family planning, however. What does assure it is if the clinic is a JPKM provider, then it must provide family planning services - all of them. But there are many skeptics who do not believe that this system will work, and many practitioners confuse it with health insurance/fee-for-service reimbursement and do not understand how it works. Action needs to be taken by BKKBN, Depkes and donor agencies to overcome these misconceptions and gain support for JPKM, especially among the medical community, the health and family planning community, and the broader donor community.

3. **The Referral Pharmacy concept is one that deserves serious examination.** If it works, it should be replicated widely. If it does not, it should be studied to determine what can be done to make it work. If it cannot be fixed, then it should be dropped, obviously. BKKBN and USAID need to sponsor a comprehensive and independent examination of this system.

5. Long-term Methods

The major emphasis was on VS and PKMI, which USAID had been supporting for 17 years. The project provided funds to continue training of medical teams, counselors, to provide IEC materials and medical equipment, to fund an external quality assurance system,

to support seminars, meetings and studies, and to test some innovations through operations research.

Most of the training, IEC materials, and equipment were provided as planned. The training curriculum was improved, but no assessment has been conducted of the effectiveness of the various training programs.

Assessments were conducted of the internal and external quality assurance systems (see Studies # 44 and 48). The results were mixed and the future of these systems is in doubt. Operations research on the social marketing of VS was undertaken (Study #35), but the pilot project could not be tested as planned because the advertising component was not approved by BKKBN. An evaluation of the "IISRF" system (Identification, Information, Screening, Referral, Follow-up) was completed recently (Study # 52). An operations research study of the quality of mobile VS teams was conducted (Study # 47). Although a report was produced, it is difficult to determine what the problem was, how the solutions were developed or what actually happened.

A large number of studies and analyses were conducted: LTM (method mixes, trends in acceptors, costs, implants - Studies # 36, 37, 38, 40, 41, 51), VS (strategy, costs, clinics, quality assurance - Studies # 42, 43, 45, 46, 49, 50, 53, 54) and PKMI (sustainability, # 39). Many of these were controversial, because the subject itself is sensitive. In summary, the conclusions were not encouraging about the future of VS or PKMI, and the recommendations required BKKBN to take responsibility for the future of both. This all came to a head at a seminar in December 1995 to review the results of the most recent research on VS costs and financing.

Midway through the project attention shifted to implant and IUD services. A major assessment was completed by JHPIEGO (not included here) and led to the development and implementation of new curricula for IUDs and Norplant, the establishment of a national clinical training network, and refresher training of thousands of physicians and midwives to extract implants that were due to be removed. An evaluation of the effect of this intervention on training and its impact on the quality of care is expected to be undertaken by JHPIEGO in mid-1996.

Although an enormous amount of resources was invested in this component, the VS and PKMI issues remain unresolved. VS is a minor method in Indonesia and is likely to remain so. Neither the VS program nor PKMI are sustainable, and USAID support for both is coming to a close. So far, neither BKKBN nor PKMI have taken any steps to address these problems.

Improvements in LTM training are well underway, with significant assistance from JHPIEGO. This program will continue and should result in the establishment of a high-quality national clinical training network. The remaining gap is in assuring the quality of care provided by providers. Recommendations made by a special Quality Assurance Design team have not yet been taken under consideration by BKKBN, much less implemented.

Lessons Learned

Although a large number of studies have been conducted, the lessons learned from them can be reduced to the following.

Voluntary Sterilization

1. **VS is a minor method in Indonesia and is likely to remain so.** The number of acceptors has declined steadily each year. Despite many years of USAID financial and technical support, the results have been very disappointing. Unless there is a radical change in government policy to support and promote VS, there is little likelihood that there will be any significant change in this situation. There is no indication that the government will change its current position. The lesson to be highlighted here is that it is fruitless for donors to continue supporting this program as long as the government is not willing to promote it.

2. **A supply side approach alone will not increase VS acceptance.** The supply side strategy has been ineffective and wasteful. Years of investment in provider and counselor training, development and refurbishing of clinics, provision of equipment, support of internal and external quality assurance systems and subsidies to providers have only resulted in an expensive supply system that is vastly underutilized. Half of the almost 4,000 VS clinics did less than six operations per year (see Study # 45). Medical experts have pointed out that this is not only inefficient, it is dangerous as well (see Study # 46). The lesson to be learned here is that a strategy that is limited to increasing and improving the supply of VS is not enough to produce increases in acceptors.

3. **The government will not address the real problem - lack of demand.** There is a great deal of unofficial support for VS within BKKBN and Depkes, but the government sees a significant political risk in promoting this method. Despite an overwhelming amount of scientific and experiential evidence that the causes of low acceptance of VS are lack of awareness and misinformation, and that religious opposition, costs, and subsidies are not significant impediments, the government is unwilling to mount a campaign to address these problems. The lesson to be learned here is that no amount of data will lead to a change in policy as long as the political risk is seen to be too high.

4. **The VS program is sustainable.** Even if the government is not willing to increase its support for the current VS program, the services can be sustained at no additional cost to the government in two ways. First, by restructuring the current subsidy system (see Study # 53) and second by financing VS through JPKM (see Study # 49). The lesson to be learned here is that one should look for alternatives to financing VS, especially when direct public financing of VS is unacceptable.

5. **The IISRF system is effective, if implemented as designed.** This system, which is dependent on interpersonal communication, and therefore labor intensive, has been shown to be effective in pilot tests and field trials. However, key elements, such as the use of satisfied acceptors as motivators, have often been left out, which reduces the effectiveness of the system. The lesson here is to follow the design and procedures of the pilot project in order to maximize the impact of the system.

6. **Quality Assurance systems are not yet practical.** The External QA system was seen to be relatively effective, but unaffordable on a nationwide scale (see Study # 44). The Internal QA system was difficult to implement for many hospitals and produced only marginally useful results (see Study # 48). A QA design team recommended some alternative approaches, but these have not yet been taken up by BKKBN or Depkes for consideration (see Study # 5). There are two lessons to be learned here. First, the replicability of a QA scheme should be assessed before it is even considered for testing.

That is, there is no point in testing systems that cannot be replicated on a national scale. Second, political commitment to QA is not yet strong enough to ensure that some sort of QA system will be incorporated into family planning services in the near future.

PKMI

1. **PKMI is not sustainable.** There is no doubt that PKMI provides important services, such as the development and updating of VS standards, that no other organization is equipped to provide. Thus, it is in Indonesia's best interests that the organization continues to operate. BKKBN and PKMI have been advised repeatedly for several years that PKMI is not sustainable as it is now structured (see Studies # 39 and 53). Yet neither organization has taken steps to deal with this problem. This is another example of the difficulty of finding solutions in the absence of political commitment. The lesson to be highlighted here is that it is pointless for donors to continue supporting an organization that the government, and the organization itself, are not willing to sustain.

IUDs and Implants

1. **Implants will be the method of the future in Indonesia.** Norplant acceptance has increased rapidly while IUD and VS have both declined. Implants are expected to replace IUDs as the most popular LTM within the next few years. The informal promotion of this method has led to the rapid increase in acceptors. Although the price is quite high (similar to VS), it requires minor surgery, and the quality of service is not up to standard, that has not limited acceptance. Clearly, the combination of government support, high subsidies, and easy access have demonstrated that specific long-term methods can be successfully promoted without jeopardizing the official "cafeteria" policy.

2. **The quality of LTM training can be improved quickly.** The recent improvements in the training curricula for IUD and Norplant have demonstrated that where there is political commitment and effective technical assistance, a major improvement in training can be achieved broadly and quickly. It should be possible, therefore, for BKKBN and Depkes to apply lessons learned from this experience to the improvement of training in other methods, and to the improvement of such related areas as supervision, quality assurance and continuing education.

Issues

1. **A National VS strategy is needed.** The strategy recommended by USAID in early 1995 has not yet been fully accepted by BKKBN, much less implemented. Neither has BKKBN developed an alternative strategy. Time is running out and a strategy needs to be developed as soon as possible. BKKBN should consider developing a series of scenarios, with outside technical assistance, if appropriate, and then selecting the one that is the most attractive, given current political, economic and demand constraints.

2. **A strategy and plan for sustaining PKMI is needed.** The same holds for PKMI. BKKBN and PKMI need to follow-up on the recommendations made at the December 1995 seminar, form a Task Force and develop a set of scenarios for consideration.

3. **A QA system for all contraceptive methods is needed.** The same needs to be done in this area. A committee already exists and has the mandate to develop a QA system for LTM, at a minimum. Recommendations for a QA system were made by a QA Design Team a year ago and need to be examined by the committee. The NRC role in QA needs to be defined. Many of the needed pieces now exist. What is needed is action to develop and institutionalize a national QA system.

4. **Competency-based training for all contraceptive methods is needed.** The IUD and Norplant training curricula and system is a model that can be expanded to cover all methods. Although this is informally accepted, it is time to take specific action to ensure that all clinical and non-clinical family planning training becomes competency-based and incorporated into the national training network.

5. **The impact of the new LTM training on quality of care needs to be conducted.** One of the most important questions about the new system is does it make a difference in services? Are the providers following the procedures as they were trained and are they complying with service standards? If they are not, the entire investment will have been an enormous waste. An evaluation of the impact of the training on the quality of services and the quality of care is urgently needed.

STUDY SUMMARIES

This section provides individual summaries of 54 studies completed under the PSFP project. They are organized by project component with 11 general studies presented first. The largest number dealt with VS (19), followed by CBD (17). About half of the studies (25) were evaluations, followed by analytical studies (19), operations research (8) and surveys (2).

Most of the study reports were prepared initially in English (34), two were prepared in both English and Indonesian, and 18 were written in Indonesian. Not all of the reports included summaries. Where available, the author's summary was used, otherwise summaries were prepared by PSG staff. English summaries were then translated into Indonesian and vice versa.

Several study reports could not be located, notably two 1994 social marketing surveys on provider attitudes and retail audits, and needs assessments for IDI, IBI, ISFI and CBD, which were done early in the project. Some studies were published separately and also included in larger reports. In that case only one was summarized to avoid duplication. Several short reports, which were distributed as memos, are included because they contain useful analytical information not available elsewhere.

It is important to keep in mind that many other studies were conducted during the five years that the PSFP project was operating that are not included here. This list is limited to those studies conducted under the PSFP project. The Population Council is preparing a data base that will include many of the other studies.

Unfortunately, there is no single depository for the reports summarized here, and some are already unavailable. The most likely sources for most reports are the Population Office at USAID/Jakarta, PKMI (for VS reports), IDI, IBI and ISFI for reports on their activities, BKKBN's Bureau of Community Institutional Development (for CBD reports), The Futures Group/Somarc office for social marketing reports, the JHU/PCS and Population Council offices in Jakarta, and the URC head office in Bethesda, Maryland, which have single copies of a number of these reports.

Each summary includes a box, such as the one shown below, that provides pertinent information about the study, including the language, location and computer file name of the original report, if known. A matrix with the same information for all 54 studies is included in the Appendix to facilitate identification of studies of interest

Topic of study: **Training, IDI, IBI, ISFI, PKMI, CBD**	Language of original report: **English**
Type study: **Evaluation**	Location of report: **USAID, PCS, URC**
Duration of study: **April-June 1992**	File name of report: **NA**
Location of study: **Central, East and West Java, Bali**	Date of report: **June 1992**
Study Director: **Huan Wan Linnan**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Author**

GENERAL

1. Evaluation of Training (6/92)

Linnan, Huan Wan. *"Final Report for Training Evaluation and Assessment Private Sector Family Planning Project".* Prepared for USAID/Jakarta, June 7, 1992.

Topic of study: **Training, IDI, IBI, ISFI, PKMI, CBD**	Language of original report: **English**
Type study: **Evaluation**	Location of report: **USAID, PCS, URC**
Duration of study: **April-June 1992**	File name of report: **NA**
Location of study: **Central Java, East Java West Java, Bali**	Date of report: **June 1992**
Study Director: **Huan Wan Linnan**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Author**

The purpose of this assessment was to summarize the important issues in the 1991/1992 training, identify problems and weaknesses of the training, and prepare recommendations for implementing training in 1992/1993. This study employed descriptive analysis as the study methodology. Data was collected through conducting focus group discussions (FGDs) among trainees from the IDI, IBI, ISFI and CBD projects. Seventeen FGDs were conducted in the provinces of Central Java, East Java and Bali. A total of 114 people participated in these FGDs. Relevant provincial BKKBN staff, CBD consultants in each province, IBI, IDI and ISFI headquarters staff, PSG and USAID project staff were also interviewed regarding the training activities. The data analysis was primarily qualitative. The results of this assessment were, to some extent, biased due to the severe time and budget constraints. The major findings and recommendations of this assessment follow.

1. Training Objectives

In general, quantitative training objectives were met in all IDI, IBI, ISFI and CBD training. However, since there were neither measurable objectives to determine the quality of this training, nor pre-post tests (except ISFI and CBD in East Java) to measure trainees' KAP change, it was difficult to estimate whether the training truly achieved what was expected. Instead of setting specific objectives for the training, most trainers used the project objectives as their training objectives. In reality, the two are very different and should not be substituted for each other. A set of measurable training objectives should be incorporated into each training.

2. Curriculum

The content of most of the curricula are appropriate and complete for the relevant projects: IDI training focused on IUD insertion and implants; IBI training focused on management and social marketing for KB service in private practice; and ISFI training focused on management, distribution of Blue Circle products, counseling and relevant laws and government regulations.

Most of the curricula are lengthy. It seems that the authors did not pay enough attention to the principle of less is more when developing these training materials. Aspects of theory seem to predominate over practical aspects in some curricula. Some of them are too complex for the trainees' educational level. Furthermore, none of the training curricula

were pretested among the target audiences. This is necessary to allow trainers to correct any miscommunications and to "fine-tune" the curricula for the trainees.

It is important to keep in mind that the users of these materials are either busy medical practitioners or government workers. Therefor, the material has to be "user-friendly" (presented in a simple and attractive fashion) if it is expected to be used by these busy people. Training materials also need to be adapted to each different level of field workers (PPLKB, PLKB, Village Chief and PPKBD). The curricula for CBD training developed by provincial BKKBN in East and West Java are good examples.

3. Training Methods and Schedule

Training methods were primarily lectures and group discussions. IDI had organized clinic sessions for their trainees to practice IUD insertion and implants. Role playing was applied in the IBI training and was particularly well received by the trainees. Except for the CBD and the ISFI training in East Java, no pre-and post-tests were given during the training. Many trainees felt that their trainers were not very dynamic and skillful. Their training methods should be more dynamic and participatory. Adult teaching methodology should be stressed during the training of trainers (TOT).

The average length of training was 2-3 days. Most of the trainees interviewed felt that their training was too short given the content they needed to learn. They wanted to add more time for role play, group discussion and practicing counseling of acceptors. Training also needs to be extended to allow time for collecting feedback from the trainees and time for visiting a good reference pharmacy or a good private midwife. The length of the training at different levels should be adjusted according to trainees' educational levels. The time for conducting provincial TOT should be reduced so that the budget can be allocated for spending more time to train the PLKB and PPKBD.

Pre-and post-tests should be added before and at the end of each training. If conditions and funds permit, a variety of teaching aids should be used to achieve better impact of the training. IEC materials need to be developed and distributed to trainees when they are taught about IEC and counseling skills during training. Trainees also should be taught circumstances under which they will use these materials.

4. Trainers

Two types of trainers were used in the training, namely experts and peers. There are advantages and disadvantages in using either of them: IBI's peer trainers were better able to communicate with the trainees. However, since they had no experience in the field of management or social marketing, it was very difficult for them to teach things that they themselves were not familiar with. In contrast, expert trainers in Bali trained both PPLKB and PLKB directly. These expert trainers were chosen to control the quality of the training and save time and money on TOT. The quality of the training was maintained. However, using expert trainers did not strengthen the coordination between the PPLKB and PLKB in the CBD activities. The training organizer should take the content of the training and the educational level of the trainees into account when selecting the appropriate trainers.

5. Change of Knowledge, Attitude and Behavior after the Training

IDI trainees -- The most important things they learned from the training were skills for IUD and implants insertions. Counseling skills were also felt to be very useful for their work. They enjoyed the certificate which allowed them to expand their field of practice. Trainees who already obtained their certificate had started to do IUD insertions in their private practices.

IBI trainees -- Important issues they learned from the training were social marketing, management of family planning services in their private practice and counseling skills. As they applied these skills in their practice, they noted that they were able to attract more clients to their practices. In addition, they were more likely to obtain a complete stock of contraceptive supplies to meet their clients' needs.

ISFI trainees -- They were able to perceive their role in the bigger picture of the national program. ISFI East Java took action to establish referral pharmacies in each area of the city and subdistrict to work with Village Cooperative Units in distributing Blue Circle products to the community. ISFI West Java developed a new distribution/price structure to take a more active role in distribution of contraceptives after the training.

CBD trainees -- The result of pre- and post-tests for East Java trainees showed that there was a significant increase of knowledge regarding the CBD component of the project after the training. Using the motivation techniques learned from the training, the PLKB were able to speed up the transition from governmental support to community self-reliance by promoting Blue Circle products and village midwife service. The West Java trainees developed tools that strengthened the management of community financing as a result of the training.

6. Post Training Supervision and Follow-up

The importance of post training supervision cannot be over-emphasized. Supervisory visits can be integrated into other routine activities to make them less costly. Except Bali, currently there is no post training supervision conducted due to lack of funds and insufficient time after the training. However, some organizations (e.g., IBI West Java) have integrated this supervision into their routine field visits, or hold monthly coordination meetings in subdistricts to coordinate family planning activities, including the CBD project (e.g., West and East Java).

7. Intersectoral Coordination for the Training

The extent that BKKBN coordinated with IDI, IBI, and ISFI training varies from province to province. In future training, this coordination should be strengthened for mutual benefit. In addition, since the CBD component of the project requires coordination among various sectors in the field, the head of the Health Center and the head of the PKK should also be trained in order to build consensus for the project. Assistant pharmacists also need to be trained since they are the ones who directly deal with clients.

8. Provide Refresher Training

As a mechanism of quality assurance, refresher training should be provided in the future. It can be in-service training of a much shorter time and on a smaller scale.

2. KB Mandiri Estimates (7/92)

Reynolds, Jack. *"Full and Partial Mandiri Estimates."* Project Support Group, Private Sector Family Planning Project, BKKBN. Jakarta, 23 July 1992.

Topic of study: **KB Mandiri**	Language of original report: **English**
Type study: **Analysis**	Location of report: **URC, PCS**
Duration of study: **June 1992**	File name of report: **NA**
Location of study: National	Date of report: **NA**
Study Director: **Jack Reynolds**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Author**

Background

The 1991 IDHS data estimated that "22.1 percent of ever-married women currently using a modern contraceptive method" received that method from a private source. This figure was widely quoted and interpreted as 1) a significant increase in the proportion who are *Mandiri* from 12 percent in 1987; and 2) achievement of the PSFP project target of 20 percent *Mandiri* by the end of 1994. Unfortunately, receiving contraceptives from a private source and being *Mandiri* are not necessarily the same thing.

This report examines and adjusts the 1991 IDHS data to estimate the percentage of current users who are self-sufficient (*Mandiri*). It also makes estimates of that distribution as full (pay the full price of the service and contraceptive), partial (pay part of the price), and pre-Mandiri (pay nothing).

The principal conclusions and recommendations of this analysis are summarized below:

Conclusions

1. The proportion of **Full *Mandiri*** users is estimated to be 13.5 percent of all users for 1991.

2. The proportion of **Partial *Mandiri*** users is estimated to be 50.2 percent of all users for 1991.

3. If these estimates are correct, then BKKBN has already exceeded an overall PSFP project objective for full and partial *Mandiri* (which was 45 percent by the end of 1994). The figure for 1991 was 63.8 percent.

4. However, many of these users are partial *Mandiri*. The proportion of full *Mandiri* users is still below the 1994 target of 20 percent.

5. The opportunities for increasing full *Mandiri* are especially attractive in IUDs and pills, since the government currently accounts for 96 percent of these markets.

Recommendations

1. Concentrate on increasing full *Mandiri*. This is the most significant category, and the most important in the long-run. In addition, there is ample room for moving users from partial *Mandiri* to full *Mandiri*.

2. Concentrate on increasing full *Mandiri* among IUD and pill users. Aim to replace the government share of both markets. If the current commercial sector is replaced, full *Mandiri* users will actually decrease.

3. Develop a long-term strategy for increasing the proportion of users of long-term methods, especially sterilization. There is ample room for increasing the proportion of users of all three methods (VSC, IUD, implants).

3. Mid-term Evaluation of PSFP (9/93)

Devres, Inc. *"Mid-term Evaluation: Private Sector Family Planning Project, No. 497-0355."* Washington, D.C. September 13, 1993.

Topic of study: **SM, CBD, PSD, LTM**	Language of original report: **English**
Type study: **Evaluation**	Location of report: **USAID**
Duration of study: **July-September 1993**	File name of report: **NA**
Location of study: **National**	Date of report: **September 17, 1993**
Study Director: **Joel Montague**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Authors**

Purpose of the Evaluation and Methodology Used

The purposes of the mid-point evaluation of the Indonesian Private Sector Family Planning Project program were: (1) To assess the achievement of project objectives to date. This assessment was to include qualitative as well as quantitative assessment of project outputs and data on end of project (EOP) indicators; (2) To assess and analyze strengths and weaknesses of key project activities; (3) To identify changes needed in objectives, strategy, and activities; (4) To identify the lessons learned especially for: (a) implementation of new service delivery expansion support (SDES project), and (b) sustainability of project activities; (5) To examine gender issues with a view to increase the information base and to begin asking the right questions so that AID can do more gender responsive and effective work in the future.

The evaluation methodology was straightforward. Prior to and after the arrival of the evaluation team in Indonesia, team members reviewed project-relevant documents such as the project paper, quarterly reports produced by URC/PSG, trip reports, survey results, and documents related to research, GOI reports, etc. The first four days in Indonesia consisted of document review, meetings with key individuals at AID, BKKBN, PSG and the many collaborating agencies as well as activities related to team formation and the assignment of primary but shared responsibility for specific evaluation topics. This was followed by field visits by two teams to areas impacted private sector family planning project activities in West Java and North Sumatra and South Sulawesi and East Java. On the return of the two teams to Jakarta, additional interviews were carried out, AID received a mid-point report, the draft final report was written and the findings were presented to AID and BKKBN officials. The report was completed prior to the departure of the team leader and was subsequently submitted to AID and BKKBN officials for their comments and suggestions.

Purpose of Activities Evaluated

The purpose of USAID's Private Sector Family Planning Project was to assist government of Indonesia's efforts to increase the availability, quality, sustainability, and use of private family planning products and private family planning services, especially through the provision of longer term contraceptive methods such as IUDs, implants and sterilizations. To achieve the project's objectives there were four interrelated activity components each of which was examined in detail. These were:

(A) Private Sector Organization Development Component (component deals primarily with training).

The findings and conclusions of this section showed that while training targets are being met statistically, it is questionable whether all the training has served the purposes of significantly increasing the number of midwives and doctors actually providing family planning services in their private practices. The team also concluded that not all IEC material was relevant and the number of IUDs and Norplant insertions did not appear to increase significantly as a result of the training provided by the project. Quality assurance was handicapped by a lack of funds. The recommendations made were (1) to remove the prohibition on midwives providing Norplant in their private practice, (2) devise ways to help midwives open and maintain private offices, (3) focus training on midwives, (4) reinforce organizational development activities with IBI, (5) place greater emphasis on infection control.

(B) The Private Sector Family Planning Program Long Term Methods Component

The general objectives of the long term methods component were to increase the use of long term methods by improving the quality of clinical and contraceptive services. The team concluded that sterilization, IUD and Norplant targets were far too ambitious. A large number of professionals have been trained. The team concluded that trainees have difficulties in implementing the skills they have learned, the ultimate sustainability of PKMI sterilization was very much in doubt and that the training counselors was of dubious utility. The team recommended (1) that the number of candidates for sterilization be selected only among those who were willing to implement their skills, (2) that the quality assurance teams did not effectively guarantee the quality of service and the internal hospital quality improvement model should be further tested and expanded, (3) PKMI needed to expand its membership, restructure its organization and develop its capability in campaigning and promoting voluntary sterilization - perhaps through encouraging further efforts in social marketing of sterilization.

(C) Private Sector Contraceptives: Social Marketing and Community-Based Distribution

The findings in the area of social marketing indicate that the Blue Circle program is unable to reach a rural market and that sales of IUDs have fallen. The team concluded that BKKBN's Gold Circle program is a useful additional program with new products and a wider market and at least two companies in the Blue Circle family are planning to continue a joint promotional effort after the end of AID funding. Recommendations are: (1) that further research be undertaken on the cost-effectiveness of mass media and (2) on a pilot basis, BKKBN should restrict free or subsidized products in urban areas where acceptors can afford to pay the Blue Circle-Gold Circle prices.

The findings and conclusions in the area of community-based distribution demonstrate that the private sector contraceptive distribution system in rural areas needs improvement and that community financing plays an important role in the strategy for achieving self-sufficiency and family planning. A CBD evaluation is now underway. Recommendations are: (1) the training of CBD workers should be less didactic and more participatory, (2) KB Mandiri and CBD achievements at the community level should be promoted through mass media.

(D) Project Management

In the area of project management, the team concluded that the project structure meets standard tests of sound organizational structure, the MIS is laudable, there have been problems with delays due to the lack of synchronization of AID/BKKBN planning and financial systems, the project staff and technical assistance have been good. Recommendations are: (1) a short term technical assistance plan, (2) MIS indicators needed on quality of care, gender, CBD and operations research, (3) a system be developed to monitor host government contributions, (4) there may be greater coordination between PSG and Pathfinder International.

(E) Sustainability

The findings were that the BKKBN has a stable organization and that PKMI and IBI will continue to need subsidies. The AID contribution to the overall BKKBN program is important but very small financially.

(F) SDES

The following conclusions were reached for AID on the SDES activity. There are now no performance-based indicators, SDES objectives are also related to increasing the use of long term methods and the Evaluation Team's recommendations on this subject should be heeded by SDES, work with midwives needs even greater emphasis, the private sector may be too narrowly defined in practice by the SDES project. Recommendations: (1) short term TA will be needed and should be budgeted, (2) further assistance might be provided in social marketing, (3) PKMI training should be redirected to demand creation under the SDES project, (4) SDES needs to start work developing performance-based indicators, (5) make efforts to synchronize finance and planning in future SDES activity.

(G) Gender

The team found that gender issues were not considered when the project was designed. Most of the training is offered to males - because most of the physicians are male and there is no major pressure to change the system. Recommendations are: (1) a task force to look at the most effective gender mix of providers, (2) a data base on gender of trainers and trainees, (3) short term management programs and fast track promotions for women in BKKBN, (4) a TV campaign emphasizing the important role of midwives.

4. History of Indonesian QA Activities(6/95)

Vogel, Russell and Jack Reynolds. *"A Brief History of Indonesian Quality Improvement Activities in Family Planning. Prepared for the FP Quality Assurance Design Team Visit, June 24 to July 14, 1995."* Project Support Group, Private Sector Family Planning Project, Bureau of Planning, BKKBN. Jakarta, June 1995.

Topic of study: **VS, QA**	Language of original report: **English**
Type study: **Analysis**	Location of report: **PKMI, USAID**
Duration of study: **June 1995**	File name of report: **NA**
Location of study: **National**	Date of report: **June 1995**
Study Director: **Russell Vogel**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Jack Reynolds**

This 10-page document provides a chronological summary of quality assurance efforts since 1983. It also describes the current status of QA activities. The headings provide a summary of both:

I. History of Family Planning Quality Assurance in Indonesia

1983: AVSC VS medical supervision system for PKMI
1984: AVSC/PKMI pilot in one then three provinces.
1985: Pathfinder/PKMI pilot project
1986: PKMI VS QA system evaluated with AVSC support
1986: BKKBN/PKMI expand system to 13 provinces with bilateral funds
1987: PKMI/BKKBN National Meeting on Quality Assurance
1988: PKMI includes informal "Internal" QA component
1988: Expansion of PKMI VS QA system to all 27 provinces
1988: AID-funded Health Sector Financing Project starts at Depkes
1990: Private Sector FP (PSFP) Project starts
1990: ADB John Snow/YKB Norplant Surveillance project
1990-93: World Bank research - BKKBN Quality Indicators Study
1991-1993: Small team develops Population Council QOC Project concept
1992: PKMI QA team supervision training - AVSC and URC funding
1992: PKMI/BKKBN expand QA System to all long term methods
1992: IBI Peer Review (QA) Pilot Project under PSFP Project
1992: BKKBN National and international QA meetings funded by Population Council
1992: BKKBN "Quality Circle" program
1992: URC QA project visit
1992: PKMI Internal QA Component pilot activity (TA from QA Project)
1993: URC QA Project also works with Depkes on QA approaches
1993: Population Council/Ford Foundation Quality of Care Project
1993/94: JIKA sponsored Quality Assurance National Meetings with Depkes
1993/94: BKKBN Contraceptive Services Bureau QA meeting and concept
1994: Pathfinder supported SDES Project starts
1994: Formation by BKKBN of a National Steering Committee for Family Planning Quality Improvement
1994: Donor Agency QA Coordination Group
1995: ASEAN Quality Assurance Meeting in Jakarta

1995: COPE Pilot Project
1995: Depkes and BKKBN attend International QA Meeting

II. Current Status of QOC in Family Planning

Environment for VS affects Quality of Care efforts
Ross/Lubis report and AID VS strategy
BKKBN Biomedical Bureau Quality of Care Model

III. Current Status of BKKBN Projects

PKMI External
PKMI Internal
IBI Peer Review
SDES quality indicator work
COPE
Depkes Health Center Peer Review
New MIS
Department of Health QA Activities

IV. Training Improvement as Part of the QA Effort

1992 Training Assessment/1993 Situation Analysis
NIIP Refresher Training
National Clinical Training Network and NRC
The current status of the Network and NRC

5. Proposed QA Strategy (10/95)

Al-Assaf, A., et al. *"A Proposed Strategy for Family Planning Quality Assurance in Indonesia."* University Research Corporation, Jakarta. October 1995.

Topic of study: **QA, VS, LTM**	Language of original report: **English**
Type study: **Analysis**	Location of report: **PKMI, URC**
Duration of study: **June-October 1995**	File name of report: **QA_DSN3**
Location of study: **National**	Date of report: **October 19, 1995**
Study Director: **A. Al-Assaf**	Funding: **PSFP**
Technical assistance: **PSG**	Summary prepared by: **Authors**

Background

A four-member team from the US and Indonesia with expertise in quality, training and family planning was assembled to conduct an assessment of ongoing QA activities and to design a QA strategy for family planning in Indonesia. The priority area of emphasis focused on monitoring and improving the provision of services at the point of contact with family planning clients, namely, in hospitals, health centers and private practice, as well as in the community.

During their three-week stay in Indonesia, the team members met with many of the key players in family planning and quality assurance, examined the various quality improvement efforts that are being carried out in Indonesia, and received suggestions for the design of the strategy. Based on this information, as well as several field visits, reports and documents received, along with other data gathered during the visit, the team formulated a preliminary strategy. That strategy was presented at a special meeting of policy-making and implementing agencies on July 14, 1995. Participants included representatives from BKKBN, Depkes, IBI, POGI, PKMI, IDI, USAID and others involved and interested in quality of care. Feedback from that meeting was used to finalize the strategy that is recommended in this report.

Findings

Indonesia is committed to improving the quality of its family planning services, both in clinics and in communities. Both Depkes and BKKBN have made considerable progress in the area of quality assurance and improvement. Many activities have been undertaken and considerable interest shown in systematically addressing the many tasks required to implement a comprehensive QA/QI program.

Over the past several years a number of tests have been carried out to identify appropriate and affordable quality assurance (QA) mechanisms. USAID has been an active partner in many of these initiatives, providing financial and technical support through the PSFP project, the SDES project and a number of Cooperating Agencies (CAs), especially JHPIEGO, AVSC, URC and the Population Council.

The activities undertaken have been diverse. They include periodic meetings of a standing committee to share ideas and experiences on quality assurance; field research to examine "structural quality" (infrastructure, facilities, equipment, etc.); pilot tests of interventions that providers can adopt; support of supervision systems that are designed to identify and

find solutions to service delivery problems; development of standards of service; improvement of clinical training to upgrade the skills of providers; and operations research to try out a hospital-based continuous quality improvement (CQI) model.

While many of these tests have produced valuable insights, and some have shown promise as QA mechanisms, much remains to be done to consolidate them into a single QA system that covers all of the health services provided by the government, and not just family planning. It is imperative that the leadership at all levels reinforce that commitment with a specific program design, with measurable goals and objectives, and with sustainable implementation strategies. It is equally important that this be an Indonesian strategy, developed to fit the culture and context of Indonesia, and not just a copy of western QA models. The challenge before BKKBN and Depkes is to prepare a national strategy that will institutionalize the many family planning quality initiatives and build on their strengths. The strategy should include construction of a comprehensive model that is not only effective in assuring quality services, but that is also cost conscious, flexible in its approach, culturally and geographically sensitive, and sustainable.

Recommendations for a Family Planning Quality Assurance Strategy

Developing that strategy, that comprehensive model, will take time. The ultimate objective should be a continuous quality improvement (CQI) model that can be applied to all health services, including family planning.

In the interim, there are critical issues within the family planning service delivery system that must be addressed immediately, especially in the provision of clinical family planning services - IUD, implant and sterilization. There are equally important areas in the provision of field-based services, in particular family planning information, education and counseling.

Consequently, the team recommends a strategy that deals with these immediate needs first while the more comprehensive CQI system is being developed and tested. The strategy has four major parts, which can be implemented in phases. The first two are the most pressing and should be seriously considered right away.

1. **Immediate: Provider QA** built into the refresher and in-service training for IUD, Norplant and VS to ensure that providers become committed to adhering to the service standards that they were trained to carry out.

2. **Intermediate: Field Worker QA** A QA system similar to the one for providers to ensure that family planning field workers and volunteers trained in IEC become committed to adhering to the standards for family planning IEC and counseling.

3. **Intermediate: Community QOC** An annual assessment of quality of care (QOC) from the perspective of the community, conducted as part of the Family Welfare Data and Mapping system, to ensure that family planning services are conducted in accordance with community values.

4. **Long-term: Comprehensive CQI System.** A system to instill continuous quality improvement (CQI) throughout the Indonesian health and family planning service delivery system.

6. Impact of PSFP on Contraceptive Prevalence and Self-sufficiency (10/95)

Reynolds, Jack. *"Contraceptive Prevalence and Self-sufficiency in Indonesia. The Contributions of the Private Sector Family Planning Project, 1991-1995."* Project Support Group, Private Sector Family Planning Project, National Family Planning Coordinating Board. Jakarta, October 1995

Topic of study: **SM, PSD, CBD, LTM, KB Mandiri**	Language of original report: **English**
Type study: **Evaluation**	Location of report: **USAID, URC**
Duration of study: **September-October 1995**	File name of report: **KBM_1994**
Location of study: **National**	Date of report: **October 27, 1995**
Study Director: **Jack Reynolds**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Jack Reynolds**

This eight-page report summarizes the impact of the Private Sector Family Planning (PSFP) project on contraceptive prevalence, fertility, use of private sector contraceptives and services, and use of long-term contraceptive methods (LTM).

The PSFP project began in October 1990 and completed most of its activities by December 1995. A six-month extension was granted to allow reprogrammed funds to be used for Norplant training and removals. The US $20 million project's main objective was to increase the use of private sector family planning products and services, especially LTM (IUDs, implants and voluntary sterilization). Most project activities were concentrated in the eight largest provinces: East Java, Central Java, West Java, Bali, Lampung, North Sumatra, South Sumatra, and South Sulawesi. Some activities, especially social marketing of contraceptives, and support for sterilization, were nationwide.

The 1991 and 1994 Indonesian Demographic and Health Surveys (IDHS) coincided roughly with the start and end of the project and were used to measure changes in key indicators at the national level and in each of the eight project provinces.

The data show that the project made a significant contribution to Indonesia's population goals.

Contraceptive prevalence increased: the use of any method increased from 49.7 percent in 1991 to 54.7 percent in 1994, an increase of 5 percentage points. Prevalence increased even more in the eight project provinces: 5.7 percentage points.

Fertility declined. The total fertility rate (TFR) declined from 3.02 in 1991 to 2.86 in 1984. The TFR declined in six of the eight project provinces. Two provinces, Bali and East Java, are at or near replacement level.

Private sector use increased from 22 percent in 1991 to 28 percent in 1994. One of the most important findings is that midwives have become the major private sector provider, accounting for more services (16 percent) than all other private sources combined (12 percent).

Long-term method use did not increase. Despite a major effort to promote increased use of LTM, especially VS, there was no significant change between 1991 (19.7 percent) and

1994 (19 percent). IUD use dropped significantly, from 13.3 to 10.3 percent. Norplant increased slightly (3.1 to 4.9 percent) as did sterilization (3.3 to 3.8 percent).

Although the project cannot take credit for all of these changes, it seems clear that it did play a key role. The Blue Circle campaign opened up the private sector, especially in urban areas, the CBD component increased private sector use in rural areas, and the training of private sector providers, especially midwives, helped to increase the supply of qualified practitioners.

The project was less successful in promoting increased use of long-term contraceptives. To increase use of LTM, potential acceptors need to be made aware of the methods available to them, and their advantages. More effort will need to be put into promotion and education of women and men about the relative advantages to them of IUDs and sterilization, in particular. At the same time, the quality of clinical services and counseling, must be raised to overcome rumors and fear of these clinical methods.

7. PSFP Final Project Report (12/95)

Reynolds, Jack. *"Final Report: Private Sector Family Planning Project, 1991-1995."* Project Support Group, Private Sector Family Planning Project, Bureau of Planning, National Family Planning Coordinating Board. Jakarta, December 1995

Topic of study: **SM, CBD, PSD, LTM**	Language of original report: **English**
Type study: **Evaluation**	Location of report: **PCS, USAID, URC**
Duration of study: **October-December 1995**	File name of report: **PSFPFINL**
Location of study: **National**	Date of report: **December 18, 1995**
Study Director: **Jack Reynolds**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Jack Reynolds**

Background

The PSFP project began in October 1990 and completed most of its activities by December 1995. A six-month extension was granted to allow reprogrammed funds to be used for Norplant training and removals. The US $28 million project's main objective was to increase the use of private sector family planning products and services, especially LTM (IUDs, implants and voluntary sterilization). Most project activities were concentrated in the eight largest provinces: East Java, Central Java, West Java, Bali, Lampung, North Sumatra, South Sumatra, and South Sulawesi. Some activities, especially social marketing of contraceptives, and support for sterilization, were nationwide.

This final report begins with a summary of the project's impact.[1] 1994 IDHS data show that:

- **Contraceptive prevalence** increased from 49.7 percent in 1991 to 54.7 percent in 1994.
- **Fertility declined** from 3.02 in 1991 to 2.86 in 1984.
- **Private sector use increased** from 22 percent in 1991 to 28 percent in 1994, but
- **Long-term method use did not increase.** There was no significant change between 1991 (19.7 percent) and 1994 (19 percent).

There are five main chapters, starting with an overview of the project followed by a description of the background, objectives, activities, results, lessons learned, and issue that remain to be dealt with for each of the four components: social marketing, community-based distribution (CBD), private sector development, and long-term methods (LTM). Appendixes summarize project expenditures, host country contributions, project activities and indicators.

[1] From Jack Reynolds, "Contraceptive Prevalence and Self-sufficiency in Indonesia: The Contributions of the Private Sector Family Planning Project, 1991-1995." October 17, 1995.

Social Marketing

The objective was to increase private sector sales of (commercial) Blue Circle contraceptives (IUD, pill, injectable, condom) in urban areas through mass media advertising (TV, radio, print), promotions, public relations, improved distribution, market research and operations research to test the social marketing of VS. These activities were managed by a marketing firm contracted to work with four pharmaceutical companies. The hope was that by the end of the project, enough demand would have been created that the pharmaceutical companies would continue to market contraceptives on their own.

At the same time, BKKBN was promoting the use of private sector providers (doctors, midwives and pharmacies). BKKBN also introduced another line of private sector contraceptives, known as Gold Circle.

The Blue Circle campaign was a huge success. Market research showed that ever use of Blue Circle was 39 percent, and current use was 28 percent in 1994. The image of Blue Circle was of a high quality, affordable product that is recommended by providers and suitable for users. Sales increased steadily through 1992 and then declined somewhat due to stockouts of IUDs and condoms, competition from generic brands of injectables, and confusion about the difference between Blue and Gold Circle products. The most successful product was the Blue Circle pill, whose sales continue to increase. Overall commercial sales, although competitive with Blue Circle, have increased. Blue Circle was effective in demonstrating that there is a market for the private sector. The 1994 IDHS showed that private sector use increased to 28 percent, from 22 percent in 1991.

Sales could be even higher in the future if stockouts and BKKBN competition can be avoided. A significant challenge that remains is to find a way to open up the private sector market in rural areas.

Community-based Distribution

CBD began in Indonesia in 1979 and has been a very successful government program. The objective of the PSFP project was to increase the use of private sector providers and contraceptives in rural areas. Field workers and volunteers were trained in three key interventions: 1) home delivery of pills and condoms for a small fee, the proceeds to be used to offset worker transportation costs and to pay transportation costs of acceptors who experience side-effects and wish to switch to a clinical method; 2) payment of monthly dues by members of acceptor groups into a community fund to pay for transportation costs of cadres and acceptors; 3) sales of Blue Circle condoms and pills by PPKBDs (community-based workers) and 4). promotion of the use of private sector services by making referrals.

USAID provided two years of funding in each of the eight project provinces to pay for training of community leaders, field workers, volunteers and others. Close to 300,000 were trained. Funds also paid for the development of IEC materials, new contraceptive distribution systems, and operations research, mostly on ways to overcome barriers to the use of village midwives.

Separate evaluations were conducted in each of the eight provinces. The data show that the field workers and volunteers were quite active in carrying out CBD activities. Over 40 percent of the eligible women interviewed said that a family planning field worker had recommended them to a private sector doctor or midwife. Over 30 percent said they had been visited in their home by a field worker who offered to bring contraceptives to them at

home. And over half of those accepted the offer. And of that group, almost two-thirds paid for the service. Over one-quarter of the respondents said that a community fund for family planning had been established, and 85 percent of those said that they were members of the fund.

Three out of four of the target population (78 percent) had seen the Blue Circle logo, and almost the same percentage (72 percent) had heard of *KB Mandiri.* About 3/4 of those know what it meant (to be self-sufficient, pay for family planning yourself). Most important, almost 29 percent of the target population was full *Mandiri* (paid the full cost), and another 43 percent were partial *Mandiri.*. That is, a combined 72 percent of the population paid something. The PSFP project objective was to reach 40 percent by the end of 1994.

The CBD program was very effective in increasing *KB Mandiri* in rural areas. But it was less successful in areas that did not have easy access to private services and contraceptives. A significant challenge that remains is to find ways to segment the rural market so that those who are willing and able to pay for family planning can do so, and those who are poor still have access to free or subsidized services.

Private Sector Development

BKKBN began working with private professional associations around 1986, when it began the *KB Mandiri* campaign. The most important of these are IBI (the midwives), IDI (physicians), and ISFI (pharmacists). The PSFP project's objective was to increase the supply of trained private sector providers: 2,500 doctors, 2,500 midwives and 2,000 pharmacists. Over 9,000 were trained by the project, over half of which were midwives.

The most successful and responsive portion of this component was IBI. In addition to training 5,428 private sector midwives in clinical and non-clinical skills, a very successful "peer review" program was developed, tested, and implemented in four provinces. This program, which is now being expanded to other provinces, is designed to improve the quality of care provided by private midwives and to strengthen the training, fund-raising and continuing education capabilities of local IBI chapters.

IDI's training program was directed at general practice physicians. An assessment conducted about halfway through the project found that this was not the appropriate target group and the training was halted.[2]

Later it was decided to explore the feasibility of setting up comprehensive health clinics under the JPKM (managed care) program of the Department of Health. This was attractive because the JPKM program includes family planning as one of its basic services - at no extra charge to members and their dependents. For a variety of reasons, the development of this pilot project has been exceptionally slow. The first three IDI clinics were opened in December 1995, almost two years after it was decided to go ahead with this pilot. Thus, there is very little that can be reported at this time, but an evaluation conducted in December concluded that the concept is a promising one.

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[2] See Jack Reynolds, "IDI Private Sector Family Planning Training: Mail Survey Results." November 1993.

ISFI's role in the project was relatively minor, especially in comparison with IBI and IDI. Although 2,000 pharmacists when through an orientation program, it appears that the more appropriate group would have been the assistant pharmacists, who manage the pharmacies on a day-to-day basis. ISFI also set up "Referral Pharmacies" which are supposed to support "Village Family Planning Posts." The idea is to improve the availability of private sector contraceptives in rural areas. Two assessments in 1992 and 1993 showed the system had serious limitations. In 1995 ISFI conducted an evaluation in East Java that was expected to be ready in early 1996.

The key lessons learned are that the midwives are the most important private sector providers, and should receive additional support. Private sector GPs and pharmacists are not key providers of family planning services. However, the managed care clinics and Referral Pharmacies are worth examining carefully, and supporting if they are effective.

Long-term Contraceptive Methods

The major emphasis was on VS and PKMI, which USAID had been supporting for 17 years. The project provided funds to continue training of medical teams, counselors, to provide IEC materials and medical equipment, to fund an external quality assurance system, to support seminars, meetings and studies, and to test some innovations through operations research.

Most of the training, IEC materials, and equipment were provided as planned. The training curricula was improved, but no assessment has been conducted of the effectiveness of the various training programs.

Assessments were conducted of the internal and external quality assurance systems. The results were mixed and the future of these systems is in doubt. Operations research on the social marketing of VS and the use of mobile teams were undertaken. The social marketing pilot could not be tested as planned because the advertising component was not approved. An evaluation of the "ISRF" component (Information, Screening, Referral, Follow-up) was still underway when the project ended. The mobile team study was designed, conducted and assessed without any significant input from BKKBN, USAID or PSG. Although a report was produced, it is difficult to determine what the problem was, how the solutions were developed or what actually happened.

A large number of studies and analyses were conducted: LTM (method mixes, trends in acceptors, costs, Norplant), VS (strategy, costs, clinics, quality assurance) and PKMI (sustainability). Many of these were controversial, because the subject itself is sensitive. In summary, the conclusions were not encouraging about the future of VS or PKMI, and the recommendations required BKKBN to take responsibility for the future of both. This all came to a head at a seminar in mid-December to review the results of the most recent research on VS costs and financing.

Midway through the project attention shifted to Norplant and IUD services. A major assessment was completed and led to the development and implementation of new curricula for IUDs and Norplant, the establishment of a national clinical training network, and refresher training of thousands of physicians and midwives to extract implants that were due to be removed.

Although an enormous amount of resources was invested in this component, the VS and PKMI issues remain unresolved. VS is a minor method in Indonesia and is likely to remain so. Neither the VS program nor PKMI are sustainable, and USAID support for both is coming to a close. So far, neither BKKBN nor PKMI have taken any steps to address these problems.

Improvements in LTM training are well underway, with significant assistance from JHPIEGO. This program will continue and should result in the establishment of a high-quality national clinical training network. The remaining gap is in assuring the quality of care provided by providers. Recommendations made by a special Quality Assurance Design team have not yet been implemented.

Conclusions

The 1994 IDHS, the Blue Circle market research, and the CBD evaluation all indicate that the PSFP project had an impact on *KB Mandiri* and contraceptive prevalence. The Blue Circle campaign opened up the private sector, especially in urban areas, the CBD project increased private sector use in rural areas, and the training of private sector providers, especially midwives, helped to increase the supply of qualified practitioners.

Obviously, the PSFP project cannot take credit for everything. BKKBN had other complementary activities going on at the same time, as did the Department of Health and the armed forces. Such non-programmatic factors as increased wealth and improved transportation also played a part. Nonetheless, it seems clear that the PSFP project did play a key role, and that the results that have been achieved will be sustained long after the project comes to a close.

The project was less successful in promoting increased use of long-term contraceptives. But research, analysis and demonstrations undertaken by the project identified the steps that need to be taken to increase LTM acceptance. The demand is definitely there, but it is largely latent demand, not yet manifest. To increase use of LTM, potential acceptors need to be made aware of the methods available to them, and their advantages. More effort will need to be put into promotion and education of women and men about the relative advantages to them of IUDs and sterilization, in particular. At the same time, the quality of clinical services and counseling, must be raised to overcome rumors and fear of these clinical methods.

8. Final Evaluation PSFP (12/95)

Johnson, Charles N. and Keys McMannis. *"Final Evaluation: Private Sector Family Planning Project Indonesia - Project No. 497-0355".* Prepared for USAID, Jakarta. December 1995.

Topic of study: **SM, CBD, PSD, LTM**	Language of original report: **English**
Type study: **Evaluation**	Location of report: **USAID**
Duration of study: **October-December 1995**	File name of report: **NA**
Location of study: **National**	Date of report: **December 1995**
Study Director: **Charles N. Johnson**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Authors**

Background

The Private Sector Family Planning project (PSFP) was designed as a five year project (1989-1994 to support efforts of the Indonesian national family planning program to become more self-sufficient and reduce fertility. It was extended later to six and a half years at no additional cost. The total project budget was $28,553,300 of which USAID provided a grant of $20,000,000. The host country contribution of $8,553,000 (rupiah equivalent) was split between the government ($7,188,600) and the Indonesian private sector ($1,364,400). The host country contribution is now $9.14 million.

USAID planned this project to be its final bilateral support for the Indonesian national family planning program. USAID assistance began in 1968 and has totaled over $300 million for technical assistance, training, contraceptives and funds for local support for every aspect of population and family planning policy and program development.

The Indonesian National Family Planning Coordinating Board (BKKBN) was established in 1970 to coordinate family planning (FP) activities and develop a plan to extend services throughout the country. In a phased introduction beginning with Java and Bali and expanding to the other islands, the national family planning program utilized the Ministry of Health for clinical services and developed its own staff of field workers to promote village family planning acceptors groups and identify village volunteers to distribute non-clinical contraceptives. Starting in 1970 with contraceptive prevalence less than 5 percent of eligible couples, the programs has achieved remarkable success over the past 25 years. Data from the 1994 Indonesian Demographic and Health Survey (IDHS) show that nearly 55 percent of eligible couples now use some form of contraception, almost all modern methods. A strong family planning infrastructure has been established at all levels of government, national, provincial, district, sub-district and village. The national program is largely funded by the Indonesian government, with major donor support from USAID and AID/W, World Bank and UNFPA.

Over the past decade and with strong encouragement and support from USAID, the BKKBN has increasingly promoted the use of private sector providers to reduce the burden on the government's budget and has promoted the concept of KB Mandiri (self-reliance) which in practice means paying for family planning services. In less than ten years, private sector providers have increased their share of the market from about 12 percent in 1987 to over 28 percent in 1994.

Project Objectives

The goal of the Private Sector Family Planning project (PSFP) was to assist public and private sector actions leading to a self-sustaining system for reducing fertility from 3.4 children per women of reproductive age in 1987 to 3.0 in 1994 and 2.4 by the year 2000. The purpose of the project was to expand the availability, quality, sustainability and use of private sector family planning service in Indonesia.

The achieve the project goal and purpose, the anticipated 1994 end of project status indicators (EOP), compared to the 1987 baseline figures, included:

- increase contraceptive prevalence from 48 to 53 percent;
- increase the percentage of couple using private sector doctors, midwives and pharmacists as the source of family planning services from 12 to 20 percent;
- increase the percentage of couple paying for family planning services from 23 to 50 percent in urban area and to 40 percent in rural areas;
- increase nationally the percentage of couple paying all or part of the costs of family planning services from 36 to 45 percent.

Funding

USAID funding for the project was split between a contract with University Research Corporation (URC) ($9,400,000) and a grant to the BKKBN for local support of the four project components ($9,853,000). An additional $350,000 was used for the 1994 Indonesian Demographic and Health Survey (IDHS) and $447,000 was utilized by USAID for evaluations, audits and project management costs. Host country funding included BKKBN budget support for each project component and in-kind contributions for general project support, mainly office space; the Indonesian private sector contributed to a return-to-project fund based on sales of Blue Circle contraceptives and some marketing costs. The budget table below highlights the project funding.

PRIVATE SECTOR FAMILY PLANNING PROJECT

BUDGET SUMMARY (U.S. $ 000)

Project Activity	USAID	Host Country	Total
- Project Contractor	9,400	250	9,650
- Blue Circle campaign	475	660	1,135
- Community-based distribution	3,339	2,842	6,181
- Private Sector Delivery	2,161	1,146	3,307
- Long-term Methods Use	3,878	3,605	7,483
- Contraceptive Prevalence Survey	300	50	350
- USAID evaluation, audit and project management costs	447	0	447
TOTAL	20,000	8,553	28,553

The contract with URC provided funds for a team leader, six long-term technical advisors, short-term technical specialists, a Project Support Group (PSG) to manage the project, procurement of computers and medical equipment, and a sub-contract with The Future Group (TFG) to support the Blue Circle campaign. Funds for local costs of the four project components were divided between the USAID grant to the BKKBN and host country contribution. Host country contributions included funds from a return-to-project fund established under the social marketing program by which each of the four Blue Circle contraceptive producers contributed 2-4 percent of gross sales for increased advertising. This fund amounted to 16 percent of host country funding for the project. Each of the four project components was implemented by the relevant bureau within BKKBN.

Achievements

Overall, the project has been successful. The contractor provided an excellent team of long-term advisors who collaborated well with their BKKBN counterparts, with USAID staff and with staff of the many Cooperating Agencies (CAs) working in Indonesia. The accomplishments of the project have been significant and can best be described by showing the major planned targets and the realized results for each of the four project components.

A. Private Sector Delivery

Activities under this component were managed by BKKBN's Bureau of Integrated Program Services and implemented through grants to the national associations of doctors, midwives and pharmacists. To promote greater use of private sector service providers, the project planned to train 2,500 doctors, 2,500 midwives, and 2,000 pharmacists in family planning. The numbers actually trained were 1,682 doctors, 5,428 midwives, and 2,000 pharmacists.

The number of midwives trained was nearly double the planned amount. Midwives were anxious to receive the training and put the training to good use. The 1994 IDHS showed that midwives are by far the most popular private sector source of family planning services for Indonesian couples, serving nearly 58 percent of private sector clients.

Training of doctor was terminated. It was hard to find doctors willing to devote time to the training and it became apparent that general practitioners were not a popular private sector source for delivering family planning services. Similarly, pharmacists proved to be a minor source for providing family planning information and services. Training materials have been developed, tested and are in use.

The Indonesian Doctors Association (IDI) has developed several model clinics to demonstrate that comprehensive health clinics under JPKM will increase significantly the private sector provision of unsubsidized FP services and do it in a sustainable manner after JPKM has been established beyond the demonstration phase. The Indonesian Midwives Association (IBI) depends largely upon volunteers to manage its headquarters, as well as provincial and district branches. Even with staffing limitations, IBI was able to implement a highly successful training program with project technical assistance (TA). The IBI could use more assistance in strengthening its national headquarters operations and thus provide more services to the branches. Continuing support is needed for IBI branches as well, since they are responsible for most midwife training.

The major lesson learned is that midwives already play a key role in providing family planning services through the private sector; they are enthusiastic to receive better training; and their role will likely increase in the future.

B. Community-Based Distribution of Contraceptives

Activities under this component were concentrated in the eight most populous provinces and were managed by BKKBN's Bureau of Community Institutional Development.

The major activity involved the training of 286,608 BKKBN fieldworkers, volunteers and community leaders over a three year period. Fieldworkers and volunteers were trained to distribute non-clinical contraceptives for a small fee, refer clients to private providers, promote the use of long-term contraceptive methods (LTM) and set up community contraceptive funds to help families not able to afford contraceptives. Community leaders were oriented to the importance of couples having the opportunity of becoming self-reliant in matters of family planning (KB Mandiri).

Surveys of the outcomes of this component prompted the PSFP project staff to categorize CBD and social marketing as one of the most successful project interventions. There has been a remarkable change in attitude among field worker and rural family planning acceptors away from the previous idea of free services to a willingness to pay. The concept

of KB Mandiri is fairly well known as is the Blue Circle logo (although often confused with the BKKBN's "two children are enough" slogan). Forty percent of survey respondents had visited a private provider; however, only 31 percent actually used the private provider for FP services. Each province developed a distribution system to provide commercial contraceptives to rural communities.

The PSFP project utilized practical operations research studies to monitor progress and identify problems. many studies dealt with problems faced by the new village midwives (bidan di desa), the group projected to become the lynch pin of a successful rural KB Mandiri effort in the future.

Three issues concern future sustainability of CBD. First is the fragile and not especially profitable private sector contraceptive distribution system in rural areas. Second, bidan di desa will need continuing refresher training to assist them in persuasion skills and managing their small businesses. Third, there may be an economic incentive problem because CBD workers have more to gain financially by promoting short-term methods rather than long-term contraceptive methods.

The major lesson learned is that a significant number of rural couples are willing to pay fully or partially for quality contraceptive products. Secondly, the BKKBN has demonstrated that it can organize and implement massive training programs with only limited donor technical inputs.

C. Social Marketing - Blue Circle Campaign

In terms of national and international recognition, this component is the flagship of the PSFP project. Managing this complex set of interventions involved USAID, BKKBN, the PSFP project contractor and sub-contractor, a management sub-contractor, four large pharmaceutical companies and their distributors. Efforts to reach urban middle and lower income customers for contraceptive sales included market research, strategic planning, mass media advertising, public relations, and establishing credit systems for providers.

Blue Circle (BC) activities were managed by The Futures Group and their Indonesian partner, PT Mecosin, whose name was changed later to PT Unggul Wirya Adicitra (UWA). Under the PSFP project, this component was under the direction of BKKBN's Bureau of Information and Motivation (BIPEN).

BKKBN and USAID initiated a social marketing program in the mid-1980s, beginning with the Dua Lima condom. The BC campaign began a few years later, first with a mass advertising campaign to identify the BC logo with private providers. The next step was to introduce specific BC contraceptives, a pill, IUD, injectable and condom. Under the PSFP project, the BC program was planned for three years and later extended an additional six months.

Results were remarkable. The 1994 IDHS showed that 28 percent of eligible couples were using the private sector for their contraceptive needs, compared to only 12 percent in 1987. While the BC contraceptives were mainly distributed in urban areas, mass media advertising reached nationwide, facilitating efforts of CBD workers to penetrate the rural private sector. The BC campaigns and service providers convinced a majority of survey respondents that BC products were accessible, affordable and high quality.

There are three elements necessary for success and sustainability of contraceptive social marketing: affordable and accessible products; quality providers and quality products; and effective promotion. The Indonesia program had all three components until April 1995 when BC advertising ended as scheduled.

Similar to the CBD component, the major lesson learned is that people are willing to pay for good quality contraceptives. A second lesson is that without mass media promotion, the private sector share of the contraceptives market would not have more than doubled. A third lesson is that what happens in the private sector should be important to BKKBN; for future sustainability and self-reliance, BKKBN needs to consider additional ways of supporting the private sector provision of FP services. In view of the importance of product promotion to the expansion and sustainability of the private sector component, the mission should discuss the importance of continued support for promotion to the success of both the CBD and commercial sales aspects of the private sector.

D. Long-term Contraceptive Methods

The overall objective of this component was to increase the use of long-term contraceptive methods (LTM) by improving the quality of clinical services. Under prior projects, USAID funds helped renovate and equip hundreds of clinics for LTM, especially voluntary sterilization (VS), trained doctors, and supported the Indonesian Society for Secure Contraception (PKMI) to promote VS and to establish, introduce and monitor quality control.

Because long-term contraceptive methods (LTM) tend to be more effective, cheaper in the long-run, and provide more couple years of protection per unit, the BKKBN and USAID set two targets for this component:

- Increase the proportion of current users of LTM (IUDs, VS, and implants) from 35 percent in 1987 to 41 percent by 1994; and
- Increase annual VS procedures from 130,000 in IFY 1988/89 to 292,000 annually by IFY 1993/94.

Most of the USAID and BKKBN funds under this component were used for VS. The LTM component was the largest of the four components. BKKBN funds were utilized for reimbursements to hospitals for each VS procedure. This BKKBN subsidy is now about Rp. 5 billion annually (approximately US $2.2 million). The Indonesian Society for Secure Contraception (PKMI) managed VS activities in coordination with BKKBN's Bureau for Contraception Services (BISEP). IUD and Implant training for private sector general practitioners was implemented by the Indonesian Doctors Association (IDI) in coordination with BKKBN's Bureau of Integrated Program Services (BINSI) under the Private Sector Delivery project component.

Component targets fell short of planned levels. Use of LTMs increased only marginally to 36.5 percent in 1994. The number of VS procedures has declined steadily each year since 1989. The use of IUDs has also fallen from 13.2 percent of eligible couples in 1987 to 10.3 percent in 1994. Only increased use of contraceptive implants kept the percentage of LTMs from declining.

The number of VS procedures reached a high point of 154,294 in IFY 1989/90 and has fallen each year since to only 103,026 procedures in IFY 1994/95. Tubectomies accounted for 72 percent of all VS procedures in 1989/90; by IFY 1994/95 they represented 84 percent. Causes of the rapid decline in VS are numerous: prohibition by the government of mass media promotion, the continuing ambiguous family planning status of VS (a medical procedure, not a family planning program method), opposition from Islamic leaders because of its permanent nature, and competition from IUDs and implants which provide women with long-term protection without an operation. According to the 1994 IDHS, VS remains the least known family planning method.

Part of the decline in both VS and IUD use may be due to the vigorous promotion by BKKBN of the contraceptive implant and its acceptance by increasing numbers of women. Implants represented only 5 percent of eligible couples according to the 1994 IDHS, up from 3 percent in 1991. BKKBN estimates that implants will reach 1.2 million annually by the end of its current five year plan (IFY 1998/99).

Although VS is still not considered an official family planning program method BKKBN continues to provide a subsidy to public and private providers for each VS procedure, a significant drain on its resources.

USAID and AID/W contractors have supported PKMI for almost two decades, yet it remains completely dependent on donor funds. Little effort was focused for most of that time on financial sustainability; rather, the aim was to help introduce and promote VS. PKMI provides some valuable services, such as training, introducing the latest technology, developing and implementing quality assurance standards for VS, and monitoring VS program performance. Little has been done so far to have the costs of these services assumed by the BKKBN. With USAID funding through the SDES project ending within three years, the issue of PKMI's future role and funding need to be addressed and resolved. A good start was made at a meeting held at PKMI on December 14, 1995.

The major issue regarding sustainability of LTMs is not the role of a particular method, but the mix. According to a proposed revision of its five year plan, BKKBN anticipates slight annual increases in VS and IUDs, and a 300 percent increase in implants. By IFY 1998/99, BKKBN propose to insert 1.2 million implants compared to 350,000 this year. This creates a huge demand for both insertions and removals of implants and will require a major training effort.

The major lesson learned is that a successful VS program requires publicity and strong government support. Expansion of facilities, provision of equipment, training staff, and development of standards and monitoring capability are not enough. For the most part, VS as a percent of CPR has been declining throughout Asia, markedly so in Bangladesh, the Philippines and Indonesia. In part, this is a result of couples having other long-term choices and in part more young couples who want to space are entering the system. As more and more low parity couples begin contracepting in Indonesia, VS will decline further as a percent of CPR. USAID should cut its losses on further investment in this area.

SOCIAL MARKETING

9. Social Marketing Trends (6/92)

Smith, Janet. *"Trends in Contraceptive Sales and Social Marketing in Indonesia."* The Futures Group, OPTIONS for Population Policy, Washington, D.C. June 15, 1992.

Topic of study: **SM**	Language of original report: **English**
Type study: **Analysis**	Location of report: **TFG**
Duration of study: **June 1992**	File name of report: **NA**
Location of study: **National**	Date of report: **June 15, 1992**
Study Director: **Janet Smith**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Author**

Indonesia's national family planning program faces important and evolving program directions in which critical policy decisions must be made. It is vital to support these with the fundamental analysis needed to ensure the best outcomes. The directions and decisions have to do with two aspects of the public sector program, 1) its provision of reduced price contraceptives and 2) the potential development of a new program, Gold Circle, for sales of government-procured contraceptives through community-based distribution (CBD) and private sector channels. As such, the policy decisions bear on a number of key aspects of the development of the Indonesia program, e.g. potential role the private sector and contraceptive social marketing, public sector recurrent cost recovery, optimal pricing of contraceptives with respect to usage, and segmentation of the market for contraceptive products.

The national family planning program is a holistic entity; any changes in one part are reflected in the operations of other parts. Thus it is not only legal and regulatory barriers which may impinge on private sector service delivery, but the actual operation of the public sector program -- and its successes and failures -- that affect the private sector's ability to be a full partner. The changes under consideration bring into high relief the implicit objectives of the Indonesia national program: the move increase prevalence; the concern for broad-based resource support and private sector participation; and equity access of all Indonesian families.

Recently Indonesia has put increased emphasis on the private sector as a partner in development. Under the national family planning program, the Blue Circle commercial marketing program has been established to put affordable contraceptives in the market place. Another part of the social marketing effort has been to promote Blue Circle contraceptive sales have grown steadily, although more slowly than projected. Its efforts to develop the commercial market have also been successful in attracting additional manufacturers to introduce affordable products.

At the same time, public sector pill provision had the largest share, 13%, and private sector pill provision was eighth with 1.5%. In Indonesia, there is an informal but widespread practice of consumers paying for public sector contraceptives. Whether free or sold, public sector contraceptives cost the consumer less than Blue Circle products. The present situation, thus, is one of the coincidental, but direct and unequal competition of one part of the national program with another.

Given the government's commitment to developing the private sector in Indonesia's economy, its interest in increasing family planning usage and its policy of encouraging families who can afford services to assume the costs, it is timely to look at how these objectives are being achieved in the national family planning program. Subsidized distribution may stimulate widespread use of affordably-priced contraceptives, but also locks-in recurrent costs of procurement of subsidized contraceptives. Widespread availability of reduced-price contraceptives does not encourage consumers who could otherwise afford commercial products to use them, raising issues of targeting of subsidies. There fill further be a continued need for free services to the poor to sustain their use of family planning, as well as mechanisms to insure use of effective methods by all families for whom they are appropriate.

The Indonesia national family planning program has been enormously successful. In the private sector, a commercial market exists where none existed before. The public sector has likewise demonstrated considerable capacity. Program planners and policy makers may now consider bringing market segmentation directly into the national system. This would involve analyzing the consumer market for products of all types at every price level, from the most expensive to free supplies. Ideally, a range of market niches would be identified, and products would be priced, packaged and actively marketed to their target audiences. The objective of the system would be appropriate us of family planning and maximal family financial participation of families who can afford to pay. In the evolution of Indonesia's family planning program, all that is needed now is a hard look at the consumer market and a policy commitment to employ market segmentation and let it succeed. In a thriving program like Indonesia's, the necessary implementation mechanisms are in place for such a system to flourish.

10. SRI Omnibus Survey (6/94)

Survey Research Indonesia. *"Blue Circle Contraceptives. SRI Omnibus. Management Summary."* Prepared for PT Unggul Wirya Adicitra. Jakarta, June 1994.

Topic of study: **SM**	Language of original report: **English**
Type study: **Survey**	Location of report: **SRI, TFG**
Duration of study: **March-June 1994**	File name of report: **NA**
Location of study: **Jakarta, Surabaya, Bandung, Medan**	Date of report: **June 1994**
Study Director: **NA**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Jack Reynolds**

Background

This report provides a summary of the findings and detailed tables from a random survey of 2,028 women aged 15 and over from the A, B, C, D, and E socio-economic strata in the four largest cities in Indonesia: Jakarta, Surabaya, Bandung and Medan. The survey was conducted between May 30 and June 21, 1994 as part of SRI's regular, bimonthly Omnibus survey. Similar surveys were conducted by SRI in 1989 and 1992. The report presents data from all three years for comparison.

Findings

1. Overall, awareness of the Blue Circle logo among women 18-39 has remained high and steady since 1992 (both are 94%). However, there was a slight decrease among the BCD groups and an increase in the lowest E group.

2. Television (46%) has the highest impact on awareness, although that decreased from previous surveys (52%). Awareness of the individual contraceptive methods available under Blue Circle rose steadily, as did awareness of the private sector sources for these methods.

3. Incidence of past and current use of a Blue Circle contraceptive has increased continuously. "Ever use" rose from 9% in 1989 to 39% in 1994; and "current use" rose from 7% to 28%.

4. Usage of the Blue Circle pill, IUD and condom increased, while that of the injectable decreased.

5. The private midwife remains the most important source of Blue Circle products.

6. One-third of current users specifically asked their doctors/midwives for a Blue Circle contraceptive.

7. The price of Blue Circle products is now seen as less affordable than previously.

8. Awareness of Blue Circle advertising increased dramatically in 1992 (from 40% to 80%), but decreased to 68% in 1994. The original ad "Ya, Ya, Ya" achieved a much higher awareness (62%) than the later "Rabbit's Wish) ad (11%).

9. The main messages recalled are "Two children is enough" (24%) and "BC contraceptives are good quality" (13%).

10. The interest in buying Blue Circle contraceptives has increased ("definitely will buy" rose from 25% in 1992 to 38% in 1994). The reasons for buying Blue Circle relate to "less/no side effects" and perceived product quality.

11. The image of Blue Circle products is strong relative to BKKBN and branded products. As in 1992, BC products are seen as reliable, good quality, have fewer side effects, and are recommended by doctors and midwives.

12. One tenth of married women 18-39 are aware of the Gold Circle logo. Awareness is higher in higher socio-economic groups.

11. Blue Circle Final Report (11/95)

PT Unggul Wirya Adicitra. *"BC Contraceptives End of Project Report, 1991-1994."* Submitted to USAID/Office of Population, OPH/USAID/Jakarta, BKKBN Central Office, Somarc/TFG. Jakarta, November 1995.

Topic of study: **SM**	Language of original report: **English**
Type study: **Evaluation**	Location of report: **TFG**
Duration of study: **September-November 1995**	File name of report: **NA**
Location of study: **National**	Date of report: **November 1995**
Study Director: **Robby Susatyo**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Jack Reynolds**

Background

Blue Circle had its origins in the successful Dua Lima condom promotion campaign (1986-1989), which was followed by the launch of the complementary Blue Circle Service Provider Campaign (1987) and the Blue Circle Contraceptive Products Campaign (1988). The Provider Campaign was managed by BKKBN and the Products Campaign by PT Mecosin Kasita Bahagia (now known as PT Unggul Wirya Adicitra). These campaigns were combined under the Private Sector Family Planning Project from 1990-1994.

This report focuses on the Products Campaign, through which four contraceptives (pills, IUD, injections and condoms) were produced, packaged and distributed to private sector outlets by four participating pharmaceutical companies. These companies agreed to reduce the prices of their contraceptives and aggressively distribute them through existing channels in return for an exclusive license to use the Blue Circle logo and marketing support (market research, advertising, public relations, and government promotion). At the end of the project, demand was expected to sufficiently high to encourage the companies to continue marketing these products to the public without further subsidies. Other companies were expected to enter the market as they witnessed the growth of Blue Circle. Increased competition would serve to keep prices down as well as expand the market. This is exactly what happened.

Objectives

"Blue Circle" was a four-year, USAID-funded social marketing project to promote the family planning program in eight Indonesian provinces. Four key objectives were set at the inception of the project:

1. Increased **sales** of the private sector commercial contraceptive products,

2. **Promotion** of commercial contraceptives: awareness building, positive image formation, consumer behavior change from a habit of getting free contraceptives to buying them,

3. **Distribution** of commercial products to be accessible by the lower middle income group who can afford to buy them,

4. **Sustainability** of the program. Having built a private sector market at affordable prices, the new converted consumer behavior must be sustained.

The project applied a social marketing approach, utilizing all modern marketing techniques, establishing collaboration between the private and public sectors, and relying on government commitment to successfully achieve all four of these objectives, as well as the overall end-of-project objective of annual private commercial sales of three million CYPs by the end of 1994.

Results

At the end of the project all four manufacturers agreed to continue marketing their Blue Circle contraceptives and BKKBN extended their right to use the Blue Circle logo through 1998. Prices have remained moderate, and although most mass media advertising has ended, the Blue Circle line continues to be promoted to providers and awareness of Blue Circle is almost universal among married women of reproductive age (94%). The Blue Circle spot ad, known popularly as "Ya, Ya, Ya," is equally well-known. A variety of point of sale materials, signs for providers, and public relations events for consumers and providers alike, proved highly effective in raising awareness of Blue Circle. Special distribution programs were tested, including Midwife Seminars and the Rural Sales Visiting Program (RSVP), and found to be very effective.

Retail audits were conducted monthly between April 1992 and March 1994. They showed significant improvements in market penetration (private doctors, midwives, pharmacies and drug stores), purchases and sales of Blue Circle products. Market research identified consumer and provider knowledge, attitudes and practices and showed that by the end of 1994 awareness of the Blue Circle logo was 94%, ever use of a Blue Circle contraceptive was 38%, current use was 28% and likelihood to buy was 62%. The image of Blue Circle was very positive: affordable, good quality, reliable, suitable, has less side effects, and is highly recommended by doctors and midwives.

Sales peaked in 1992 at 880,000 CYPs and dropped to around 760,000 in 1994 due to stock outs and competition. Overall commercial sales, however were thought to have at least met, and probably exceeded the goal of 3 million CYPs.

Although the project was a clear success, it was not problem free. Private-public sector philosophies and procedures were not always compatible, legal and regulatory restrictions constrained promotion and distribution, the condom and IUD factories reduced production for an extended period, thus limiting supply. Blue Circle would have been even more successful if these problems had been resolved.

Blue Circle has become a world famous success story in population and family planning circles. Almost anyone visiting Indonesia to learn about family planning will want to look at the Blue Circle program. Within Indonesia, the private sector contraceptive market is now firmly established and continues to expand, thanks to the pioneering efforts of the Blue Circle program.

COMMUNITY BASED DISTRIBUTION

12. OR: *KB Mandiri* and Village Midwives, West Java (12/94)

Budiarto, Eko, Ayip Rosidin and Dodih Suryadi. *"Improving Rural KB Mandiri through Improving the Distribution of Contraceptives, Private Sector Midwives and Community Participation in West Java."* BKKBN Provincial Office, West Java. December, 1994.

Topic of study: **CBD, Midwives, *KB Mandiri***	Language of original report: **Indonesian**
Type study: **OR**	Location of report: **BIPIM**
Duration of study: **April 1993-November 1994**	File name of report: **NA**
Location of study: **West Java**	Date of report: **December 1994**
Study Director: **Eko Budiarto**	Funding: **PSFP**
Technical assistance: **PSG**	Summary prepared by: **Author**

Background

This OR study is identical to six other OR studies carried out under the CBD component of the PSFP project. The objective of this study was to find a way to encourage village midwives *(bidan di desa)* to stay at their assigned work sites and to also open private practices. This would optimize their functions within the villages and increase the number of *KB Mandiri* participants in rural areas. To support this, the intensity of the PPKBD/SubPPKBD role (motivation, referral, IEC) has to be strengthened and the ease of distribution of contraceptives to the village level (to the midwife) has to be improved. This study was performed in four regencies in West Java. The final evaluation of the project was carried out in the same four regencies, from which three villages were selected from each, and in each village 30 eligible couples (ELCOs) were selected. Ten PPKBD/SubPPKBDs were selected from each regency so that the total number of respondents was 360 ELCO, 40 PPKBD/SubPPKBD, and 92 midwives.

Intervention

The intervention that was implemented gave emphasis to strengthening those things that would optimize the functions of the village midwives, including rearranging their placements in the villages, providing service sites for village midwives and, putting in order the *KB Mandiri* service mechanism to be provided by the midwives, marketing and promoting midwives service in the villages (coordinating or supported by PPKBD/SubPPKBD), rearranging the private contraceptive distribution channel to the midwives in the villages (through the referral pharmacy or BKKBN cooperative) with the support of the local FP liaison workers, i.e. the PPKBD/SubPPKBD.

Results

The results achieved are as follows: midwives that stayed at their places of service have reached 74 percent, from only 24 percent previously. FP participants reached 84 percent, the highest FP service provided by the midwives that is used by the public is the injectable method at 48 percent (previously injectable acceptor service was 37 percent). For *KB Mandiri* service, 77.4 percent of the public paid (which previously was 73.7 percent). The largest payments made by community members to the midwives for services (the highest is Rp 3000-4000) reached 28. 3 percent, previously it was 17.8 percent). The greatest area of

cooperation between midwife and PPKBD or SubPPKBD is motivating ELCO (77 percent). The midwives source of contraceptives from pharmacies increased 10 percentage point (before it was 30 percent, after the evaluation it became 40 percent)

Conclusions

The number of *KB Mandiri* acceptors resulting from midwife's service has increased after the intervention. The use of midwife services by the community is quite high and this has been fulfilled by those midwives who are willing to stay in their places of service. The cooperation between PPKBD/SubPPKBD and midwife in *KB Mandiri* services is starting to work. The Blue Circle contraceptives needed by the midwife are adequately available and affordable, which is due to the distribution through the pharmacy.

Although visible results can be seen from the above intervention, it still needs to be improved, so that the midwife services can be better optimized. Based on this evaluation, there are still problems which must be considered, e.g., there are still midwives who are not staying in their assigned villages. IEC materials for the PPKBD/SubPPKBD on *KB Mandiri* is minimal. Some acceptors, with Rp 3,000 contribution from the community fund, are still served in health posts or health centers.

Recommendations

To further increase the achievement of rural *KB Mandiri* in West Java through improvements in the contributions of midwives, several recommendations can be made:

1. It is best that the model intervention that was is developed for this OR study be continued and developed in other regencies in West Java.

2. Rearrangements should be made in midwife placement is carried out so that they stay in their assigned sites through cooperation between BKKBN and the local health department as well as the local government.

3. PPKBD/ SubPPKBD should be equipped with *KB Mandiri* IEC material media so that they can intensify their activities.

4. In developing the liaison worker to become a Village Family Planning Contraceptive Post working on distribution activities between the Referral Pharmacy and the village midwives, it is best to develop cooperation between ISFI (the Indonesian Pharmacists Association) and BKKBN, as well as the local health department.

13. OR: *KB Mandiri* and Village Midwives, Central Java (12/95)

Darmono. *"Improving KB Mandiri through Village Midwives and Community Participation in Central Java. Evaluation Results 1995."* December 1995.

Topic of study: **CBD, Midwives, *KB Mandiri***	Language of original report: **Indonesian**
Type study: **OR**	Location of report: **BIPIM**
Duration of study: **May 1993-October 1995**	File name of report: **NA**
Location of study: **Central Java**	Date of report: **December 1995**
Study Director: **Darmono**	Funding: **PSFP**
Technical assistance: **PSG**	Summary prepared by: **Nurfina Bachtiar**

Background

This study is one of the six OR studies that was carried out under the CBD component of the PSFP project. The objective of the study was to optimize the functions of the village midwives in conformity with their assigned FP tasks, which are to provide FP IEC and services with the involvement of the FP field workers, so that the prevalence of *KB Mandiri* increases in rural areas. Beside that, is to increase the referral to village midwives for *KB Mandiri* services as well as to increase the ease of distribution of Blue Circle and Gold Circle contraceptives to the villages. This study was carried out in 8 villages, which were selected from 8 subdistricts in 4 regencies in Central Java. The evaluation was performed basically through a survey, the sample of which consisted of 2 village midwives, 20 ELCOs, 2 PPKBD and 4 SubPPKBD from each village, so that the total number of respondents was 243 people (2 villages had only 16 and 19 ELCOs).

Intervention

The interventions include: increasing *KB Mandiri* IEC (providing manuals to FP workers), enforcing community "self-help" funding (through an "*arisan*" system,[3] "*jimpitan*"[4] and a saving and loan cooperative), and development of a Blue Circle and Gold Circle contraceptive supply system through referral pharmacies. This activity is to be carried out gradually and continually through the development of a network that involves the FP field workers, subdistrict FP trainers, village midwives and the local FP motivators.

Results

The basic survey was carried out between the end of 1992 and early 1993, and evaluation was done after intervention was performed in the early 1995. The result was as follow: *KB Mandiri* information source from midwives in the village, risen by 4.6 percent (previously 3. 8 percent after intervention became 8. 4 percent).

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[3] Arisan is defined as a regular social gathering whose members contribute to and take turns at winning an aggregate sum of money.

[4]Jimpitan is a Javanese word that refers to a rice fund that community members contribute to for the poor.

FP workers as a source of *KB Mandiri* information declined 9.4 percentage points (from 47.5 percent before the intervention to 38.1 percent after). Those who received information through TV increased 2.8 percent.

The number of active acceptors did not changed, but there was an increase in FP method use. Before the intervention were 10 percent used pills, 45 percent injectables, 15 percent IUD, 12. 5 percent were non-users. After the intervention pills users were 19.4 percent, injectables 48.4 percent, IUD 14.9 percent. Pills, injectables and IUDs, according to the ELCOs, are best obtained from the village midwife (before the intervention: pills were 15.6 percent, injectables 42.5 percent, IUD 25.6 percent and after the intervention it became: pills 25.8 percent, injectables 50.3 percent, IUD 32.3 percent).

For the majority of ELCOs, their perception of the tasks of the village midwives as a provider of health services for mothers and children, and also as a place for referrals, consultation, and FP service center, increased (from before the intervention, the midwife as a source of referrals was 2.5 percent, consultations 36.9 percent and family planning services 36.9 percent; after the intervention it was 22.6, 53.1 and 53.1 percent respectively).

The source of contraceptive supplies for village midwives was largely from the pharmacy (18.8 percent before and 37.5 percent after the intervention). The total ELCOs who paid increased from 83.1 percent (before the intervention) to 98.9 percent (after the intervention.

Start up capital for the PPKBD was collected from the community self-help funding activities, averaging between Rp 25,000 to Rp 970,000. After the community was mobilized to contribute, an increase could be seen, averaging Rp 80,000 to Rp. 3 million. This money was not used exclusively for FP activities, but also for the members' welfare.

Although the results achieved were quite good, there still were constraints that need to be handled. Those constraints are, according to the FP workers are in contraceptive distribution, knowledge/IEC, as well as community mobilization. Referring to IEC/knowledge, according to the FP worker it is best that the information on FP is provided through the FP field workers. The community mobilization is felt to still be low, more activity is needed, workers need to be more motivated to undertake their tasks.

Conclusions

From the above evaluation results, it can be seen that there has been an increase in the functioning of the midwives as providers of health and family planning services and IEC. ELCOs in the community already use the village midwife's services, especially FP services, such as injectables which are becoming popular with the ELCOs. Because the use of midwife services is already quite popular among the community, automatically they get information about FP from those same midwives. Because of that, IEC that is disseminated through the FP field workers, according to the ELCOs, is declining. The total number of active users has not changed much from before to after the intervention. What has changed is only the type of contraceptive used. This is proven by the increase in the use of certain contraceptives which has caused the total in use of other contraceptives to decline. With respect to the self-help funding activities, they have already developed well. This is because, the financing system is not focused solely on FP program activities, but also includes activities from other programs. Nevertheless, these results must be

maintained. For this reason, the constraints which still exist need to be examined to find solutions to overcome them, so that the increases in *KB Mandiri* can be raised even higher.

Recommendations

1. Village midwives need to be given the competence and means to provide advice and contraceptive services to the community, including IUD and referrals.

2. Self-supporting Community-based institutions in the village need to become involved in the Blue Circle - Gold Circle contraceptive supply network so that it will become easier for the community to obtain these contraceptives.

3. The development of financing institutions with the community needs support with various efforts, including the provision of incentives and working capital so that a self-help funding system can be developed.

14. OR: *KB Mandiri* and Village Midwives, East Java (12/94)

Halim, Kesuma, et al. *"Improving Rural KB Mandiri through Improving the Role of Private Sector Midwives and Rural Community Institutions in East Java."* BKKBN Provincial Office, December 1994.

Topic of study: **CBD, Midwives, *KB Mandiri***	Language of original report: **Indonesian**
Type study: **OR**	Location of report: **BIPIM**
Duration of study: **April 1993-November 1994**	File name of report: **NA**
Location of study: **East Java**	Date of report: **December 1994**
Study Director: **Kesuma Halim**	Funding: **PSFP**
Technical assistance: **PSG**	Summary prepared by: **Nurfina Bachtiar**

Background

This study is one of the six OR studies which was carried out under the CBD component of the PSFP project. The objective of the study is to increase the number of *KB Mandiri* participants who take advantage of the services of private practice midwives (Bidan *Praktek Swasta/BPS*), by increasing the total number of such midwives, by increasing the quality of their services, by improving the capability of social institutions in IEC, and by discovering and managing funds under the supervision of the BPS. Beside that, an objective is also to secure a private sector contraceptive distribution channel to the BPS and to develop a mechanism to encourage community support for *KB Mandiri* services from the BPS. This OR study was carried out in 24 villages selected from 8 subdistricts in 4 regencies in East Java. Previously, there had been a diagnostic study performed to identify existing problems in developing the role of midwife. The final evaluation of the study was carried out in 4 subdistricts, 8 regencies and 24 villages, with a total of 192 acceptor respondent and 23 midwives, which bring the total respondents up to 215.

Intervention

The intervention that was carried out was to develop BPS services (training, promotion, supervision and management, infrastructure and financial support), with the involvement of several community institutions (their role to be strengthened more through organization, motivation, unearthing and managing community funds). In addition to this, to rearrange the contraceptive distribution channel so as to guarantee the availability of sufficient *KB Mandiri* contraceptives at an affordable price.

Results

The results achieved are as follows: the number of new acceptors served by BPS after training has increased, the highest percentage is 30.4 percent (one midwife served 25 new acceptors). The most popular contraceptive used by FP participants is the injectable (60 percent). Coordination with community institutions which support midwife services is mainly in the field looking for new acceptors (91.3 percent). Acceptors receiving FP from midwives reached 74.5 percent, due to increases in individual awareness. This is likely to have had something to do with promotion by the midwives in cooperation with the community institutions (69 percent), and to the mounting of signboards (91.3 percent). Almost all midwives (87 percent) in the intervention sites received guidance and training from the BKKBN/health team.

Nevertheless, few of the public are aware that there is an institution that can assist them with *KB Mandiri* funding. Therefore, few people in the community have taken advantage of the community *KB Mandiri* funds. Few of the midwives have put much effort into promoting this, either.

Conclusions

The midwives fulfillment of the needs for quality services has also helped to increase the achievement of *KB Mandiri* services and acceptors. The improvement in *KB Mandiri* acceptors is due to, among other things, the support provided by community institutions and to promotion. The pharmacy as a contraceptive supply channel has already been taken advantage of by the midwives.

Recommendations

To achieve higher increases in *KB Mandiri*, both in East Java and in other places, the followings have to be considered:

1. Midwives who are to be placed in rural areas need to be equipped with sufficient knowledge and skills and need to be supported with a facility and equipment to enable them to develop their services.

2. All midwives need to undertake their own promotion for their *KB Mandiri* services, in addition to securing coordination with community institutions.

3. Support and supervisions, as well as guidance from the POKJA *KB Mandiri* and the community institutions can create BPS stability in providing *KB Mandiri* service.

15. OR: *KB Mandiri* and Village Midwives, North Sumatera (3/95)

Maas, Linda T. *"Improving Family Planning Self-sufficiency through Strengthening the Role of the Village Midwife and Community Participation in North Sumatera."* BKKBN Provincial Office, Faculty of Medicine, University of North Sumatera, March 1995.

Topic of study: **CBD, Midwives, *KB Mandiri***	Language of original report: **Indonesian**
Type study: **OR**	Location of report: **BIPIM**
Duration of study: **March 1994-February 1995**	File name of report: **NA**
Location of study: **North Sumatera**	Date of report: **March 1995**
Study Director: **Linda T. Maas**	Funding: **PSFP**
Technical assistance: **PSG**	Summary prepared by: **Nurfina Bachtiar**

Background

This study is one of the six OR studies carried out under the CBD component of the PSFP project. The objective of this study is to find a way to get the community to want to utilize the services of the village midwife in order to increase the number of *KB Mandiri* acceptors. This will be done by creating a contraceptive distribution channel through the village midwife and by increasing the community's role in managing the community fund. Eventually, a model will result for utilizing midwife services through a mechanism for developing community funding. This study was undertaken in two regencies. In one regency three subdistricts were selected and three villages were chosen from each subdistrict. In the other regency 5 subdistricts were selected and 2 villages were selected from each of those, for a total of 19 villages. The evaluation of the OR project was undertaken in the same regencies, with the collection of quantitative data from 400 ELCOs and qualitative data from focus group discussions (FGD) with community leaders, community institutions and midwives in each village (19 FGD).

Intervention

The intervention was designed to facilitate the distribution of contraceptives (by developing agreements with distributors, IBI, BKKBN), disseminating information widely about the existence of village midwives with the support of community institutions (promotion of midwives, appointment of PPKBD who have the potential to manage money), and by increasing the midwife's role as a provider of FP services (provide help with service facilities, make it easier to obtain private sector contraceptives), and broaden the knowledge about *KB Mandiri* (through orientations).

Results

The result achieved are as follows: the potential for the community adopting *KB Mandiri* is actually quite large (50 percent are Category FW II). Midwives who provide FP services is also high (73.6 percent), which is compatible with the proportion of the community that believes it is best for FP services to be provided by midwives (80.8 percent). The proportion of the community willing to pay between Rp 3,000 - 5,000 for services costs is 46.4 percent. The availability of Blue Circle and Gold Circle contraceptive is 96.3 percent. The information on *KB Mandiri* provided by community institutions is 94. 8 percent, and those who receive the information (ELCO community) is 95.5 percent. The majority of the community agreed with the community funding system (51.1 percent) and according to

them, the funds collected should be utilized for assisting the *KB Mandiri* service (69.2 percent).

Although the achievement seems very good, there are still problems that are obstacles. One of them is that the management of the community fund is still not good enough and only a few are active. Because of that, public awareness of the availability of community funding which can be utilized for FP services, is still insufficient. There still are difficulties in motivating acceptors to shift to the use of the private sector. Distribution of contraceptives through IBI is still not running smoothly. Although Blue Circle/Gold Circle were provided to the midwives freely as startup capital, there still are midwives who give out program contraceptives to acceptors.

Conclusions

Community potential for becoming Mandiri is quite high and they can afford to pay up to Rp 5,000. FP services offered by the midwives have started to be utilized. The providers who are most visited are the midwives (both village midwives and private practice midwives). The distribution of Blue Circle/Gold Circle contraceptive did not encounter any problems, however IBI's role is not helpful enough. The role of the community institutions in developing and managing funding has not been as it was expected to be. But their capabilities and role in motivating and persuading people to adopt *KB Mandiri*, is quite competent.

Recommendations

1. Continual supervision and monitoring is needed from BKKBN toward *KB Mandiri* management and from PPLKBs toward community institutions.

2. Village midwives should be encouraged to give priority to selling Blue Circle/Gold Circle contraceptives to families in the FW II, FW III, and FW III+ categories, so that the provision of free contraceptives will gradually be reduced.

3. Special guidance is needed from local IBI chapters toward the village midwives with respect to service quality.

4. The existing distribution channel should be maintained, only the optimization of its execution needs to be improved.

16. OR: *KB Mandiri* and Village Midwives, South Sumatera (11/95)

Hendarso, Yoyok. *"Improving the Role of the Private Sector Midwife through the Improvement of Rural KB Mandiri in South Sumatera."* BKKBN Provincial Office, South Sumatera and the Socio-Cultural Research Center, Sriwijaya University. November 1995.

Topic of study: **CBD, Midwives, *KB Mandiri***	Language of original report: **Indonesian**
Type study: **OR**	Location of report: **BIPIM**
Duration of study: **April 1994-September 1995**	File name of report: **NA**
Location of study: **South Sumatera**	Date of report: **November 1995**
Study Director: **Yoyok Hendarso**	Funding: **PSFP**
Technical assistance: **PSG**	Summary prepared by: **Nurfina Bachtiar**

Background

This is one of six OR studies carried out under the CBD component of the PSFP project. The objective is to increase the number of *KB Mandiri* participants who use Private Practice Midwives (BPS) or village midwives, to create a contraceptive distribution channel to the BPS or village midwife, and to improve the role of community institutions in promoting BPS/Village midwife services. This study was carried out in 20 villages selected from 4 subdistricts in 2 regencies in South Sumatera. The evaluation was based on a survey which included a midwife, 10 ELCOs, and 2 FP worker (community institutions) from each village, so the total number of respondent was 260 people.

Intervention

The intervention was carried out principally to increase the knowledge of midwives and community institutions about *KB Mandiri* as well as to increase the support of the community institutions (meetings were held to achieve agreement). Thus, a job manual for midwives and community institutions was compiled, which included the development of *KB Mandiri* services, contraceptive distribution systems, and orientation based on the material in that manual.

Results

Eighty-four percent of ELCOs agreed with the *KB Mandiri* program. The injectable was the method most preferred by ELCOs (30.5 percent). ELCOs who were quite satisfied with midwife services was 86 percent. Fully 66.5 percent of those who received FP services paid for them in full.

The role of PPKBD/SubPPKBD in this case was to assist in motivating the community to come to the midwife for service and to act as the contraceptive distributor for repeat acceptors. The proportion of midwives who have an adequate supply of contraceptives on hand was 57.6 percent. The major contraceptive source for the midwife was IBI and pharmacies.

Although the results achieved were quite good, nevertheless, there are still constraints which must be handled intensively. Those constraints are, the contraceptive supply in the pharmacies is not always as much as is needed (distribution is not running smoothly), besides that the price is felt to still be expensive. Village midwives as referral agents are

not yet operating smoothly because the community institutions are not carrying out their role fully. The counseling service provided by the community institutions is still weak.

Conclusions

The implementation of *KB Mandiri* has already been applied and accepted by the rural communities, and the majority are using the services of the village midwives. Over half of the areas studied already pay for FP services that are provided by village midwives.

The current distribution system for private contraceptives already uses IBI and pharmacies as the distributors (although supplies are not always provided smoothly). Community institution development still needs improvement in its quality. The manual developed for this study, is very useful both for the community institutions and village midwives, especially since it can be used as a reference for performing other tasks.

Recommendations

It is best to consider how to produce a large amount of manuals for distribution to other regencies in South Sumatera to increase *KB Mandiri*. In addition, for village midwives who are just beginning to undertake their tasks, it would be desirable to begin thinking of their tasks and roles in providing *KB Mandiri* services as well as getting them motivated to look for new acceptors. The PPLKB and PLKB need to provide guidance to the PPKBD and SubPPKBD regarding management of community institutions.

17. OR: *KB Mandiri* and Village Midwives, Lampung (12/95)

Indonesian Demographers Association, Lampung. *"Improving Rural KB Mandiri through the CBD Program of Lampung."* BKKBN Provincial Office, December 1995.

Topic of study: **CBD, Midwives, *KB Mandiri***	Language of original report: **Indonesian**
Type study: **OR**	Location of report: **BIPIM**
Duration of study: **April 1994-October 1995**	File name of report: **NA**
Location of study: **Lampung**	Date of report: **December 1995**
Study Director: **Kastubiari Wiryosceputro**	Funding: **PSFP**
Technical assistance: **PSG**	Summary prepared by: **Nurfina Bachtiar**

Background

This study is one of six OR studies that was carried out under the in CBD component of the PSFP project. The objective of the study was to develop a *KB Mandiri* contraceptive distribution system (Blue Circle, Gold Circle, other non-program contraceptives) so that these contraceptives can be distributed smoothly to the villages that have a high potential to become Mandiri, and in this way a specific contraceptive distribution model can be created for Lampung province. If the distribution of contraceptive to villages is smooth, then the number of acceptors that are self-sufficient will automatically increase and so will *KB Mandiri* prevalence. This evaluation was carried out in 24 villages selected from 12 sub-regencies in 2 regencies in Lampung province. The number of respondents from the final evaluation stage of the OR study totals 288, which was made up of 24 PPKBD, 24 midwives and 240 ELCOs.

Intervention

The intervention that was carried out was to develop a contraceptive distribution channel through IBI. The expectation was that the wholesale pharmacy would be able to sell directly to midwives rather than to IBI. The monthly IBI meeting was also to be used as a consultation forum among midwives and between midwives and the contraceptive distributors. At these opportunities, the distributors could deliver their contraceptives to the midwives at the same time giving appropriate information about the contraceptives that they were promoting.

Results

FP participant in the survey area is 81.7 percent, the type of contraceptives used are injectables (30.6 percent) pills (29.5 percent), IUD (20.4 percent) and implants (17.3 percent). The sources of service source for first visits are: private service (38.7 percent, which is mostly midwife service at 33.6 percent), and government service (53.1 percent, mostly Health Centers). But the source is different for revisits: private is 42.5 percent and government is 42.6 percent.

According to the ELCOs, 26.3 percent believe that range of contraceptives available from the village midwife is quite adequate. But 55.3 percent suggest that it would be best if contraceptives were available at the nearest place. Only 13.2 percent said that overall the supply of contraceptives in the villages are sufficient. The sources of supply for the midwives are mainly drug stores (47.1 percent) and then distributors (17.7 percent). Most

FP participants who were surveyed (83.4 percent), had paid the midwives in cash for their FP services and 16.6 percent paid in credit. The current costs of the midwife's service for pills is Rp 650 per cycle, IUD is Rp 8,754, and an injection is Rp 3,450.

According to the ELCO respondents, there are local *Paguyuban* (association) that are very helpful for FP services in the village. A *Paguyuban* is a coordinating organization made up of a group of people who assist social activities in the village. It includes those who handle/help FP activities. Included among the members of the Paguyuban are the local PPKBD. The major source of income for the Paguyuban comes from its member (82.2 percent) while the rest are assisted by the local government. The Paguyuban also distributes contraceptive and makes referrals. The majority get their contraceptive pills from Health Centers, while injectable contraceptive and IUDs are obtained from pharmacies. According to the 65 percent of the ELCO respondents, the Paguyuban really helps make it easier to get FP services.

There are two major channels of distribution of contraceptives in the rural areas, that is the community can get contraceptives locally either from the midwife or the Paguyuban.

Although the results of this OR project are quite good, there is still a constraint in the distribution of contraceptives. That constraints is sometimes the IBI meeting, which is supposed to be conducted every month, is rarely held. If this happen, the midwives must seek contraceptive sources themselves and buy them from the pharmacies.

Conclusions

The ELCOs in Lampung are already practicing *KB Mandiri*, although there are still those who get their service from the Paguyuban and Health Centers. The principal source of contraceptives for both the midwife and the Paguyuban are the pharmacies and Health Centers. The private contraceptive distribution channel comes from the pharmacy. Although the IBI meetings are rarely held, this does always cause problems, because midwives can get their contraceptive from pharmacies. However, for villages which are far from the subdistrict city and pharmacies, finding a private source contraceptives becomes a problem. Therefore, in remote areas, the contraceptives still come from the government/Health Centers.

Recommendations

None.

18. Evaluation: CBD, West Java (5/95)

CBD Evaluation Team, West Java. *"CBD Evaluation, West Java."* Faculty of Communications, University Padjadjaran, Bandung, and The Institute for Mass Communications Research and Development, Jakarta. Bandung, May 1995.

Topic of study: **CBD, *KB Mandiri***	Language of original report: **Indonesian**
Type study: **Evaluation**	Location of report: **BIPIM**
Duration of study: **November 1994-March 1995**	File name of report: **NA**
Location of study: **West Java**	Date of report: **May 1995**
Study Director: **Mien Hidayat**	Funding: **PSFP**
Technical assistance: **PSG**	Summary prepared by: **Nurfina Bachtiar**

Background

This survey is one of eight evaluations carried out in other provinces which also have the CBD program. The CBD program comes under the PSFP project. The objective of this evaluation is to see how effective the CBD program has been and how much impact it has had on *KB Mandiri* (self-sufficiency). In West Java the CBD program was carried out in 24 regencies/municipalities. The evaluation was conducted in 20 regencies/municipalities and consisted of 30 villages/clusters in 30 subdistricts. There were two types of survey respondents: first was 210 ELCO and second 210 FP workers (PPKBD and SubPPKBD). In-depth interviews were also conducted specially for the following activities: field worker training, contraceptive distribution systems, and community funds.

Results

Activities. During 1991-1993, the CBD activity program provided training to 671 PPLKB, 3,904 PLKB, 671 Camat, 7,105 Village Chiefs, 8,557 PPKBD and 50,053 PPKBD/SubPPKBD/cadres, which made a total of 70,961 workers. All activities have been performed according to the planned program.

Active participants. During the survey (November 1995), 84 percent of the ELCOs were FP participants, that includes 27 percent who used long term methods. Those who have been FP acceptors over 3 years were 45 percent; 32 percent obtained their services from the private sector; 77 percent have paid (40 percent paid fully and 37 percent partially). Over 83 percent are familiar with the names of the field workers in their areas, and 51 percent have been visited by those workers during the last three months. More than 63 percent are aware of the Blue Circle logo, but only 41. 4 percent know what the meaning of it is. The same is true of the awareness of *KB Mandiri*. Those who have heard of it is 68.8 percent and those who know the meaning is only 26.6 percent. The knowledge of Gold Circle is more of a concern, only 8.1 percent, and only 6.3 percent understand the correct meaning of Gold Circle.

Information on MKET (Most Effective Contraceptive Methods), only 32.8 percent knew the meaning of this term. But those who said the field workers suggested that they use MKET were quite abundant, that was 48 percent. Those who changed their method as a result was 16.6 percent.

Only two percent said that FP services were available in their area from private doctors, but 47.2 percent said these services were available from private midwives. The number of ELCOs who said they had visited a private doctor or midwife for consultation on FP was 52 percent. Since only 36.7 percent said that the field workers had suggested that they go to the private sector, this means that ELCO awareness of the private sector has improved.

The proportion who pay a fee to the PPKBD for delivering contraceptives to them at home varies greatly. So far 74.3 percent have paid money to the PPKBD for this service, with 45.7 percent paying less than Rp 500.

The concept of the community fund is to collect money from the community in order to obtain various kinds of family planning activities. Only 10 percent said there was a community funding activity, but all of these (100 percent) said they make a contribution in their own group. The amount of the contribution varied between Rp 100 - Rp 500 per month.

Field Worker. The field worker here is the SubPPKBD, 78 percent of whose work area covers an RW. The highest ELCO coverage for which a SubPPKBD has responsibility is more than 120 ELCO (30.5 percent cover that many). Their awareness of *KB Mandiri* is very good, that is 86.3 percent, know the correct meaning. Their knowledge about MKET is also high (78.6 percent) and 67.6 percent admitted that they have received the IEC-MKET materials. Only 41.1 percent have ever referred ELCO to a private sector provider, this is because only 47.6 percent have ever received IEC referral materials. The contraceptive delivery service they provide is mostly pills. Only 19.1 percent SubPPKBD have ever informed ELCOs about the community funding. This is because 77 percent have not received any community funding material. And also, only 13.3 percent. received IEC material on community funding.

CBD Training. In all 30 areas surveyed, all of the field workers have received CBD training. The number of participants who were trained ranged between 34-461 FP workers per site. The training material, such as schedules, training items, and IEC materials, were all given to the participants. There are 5 topics that they said they needed in the training: the *KB Mandiri* Movement, *KB Mandiri* Contraceptive Distribution, *KB Mandiri* IEC, *KB Mandiri* Contraceptive Services, Community Funding as well as Recording and Reporting. The time used to present each topics averaged 30 minutes. According to the participants, the training materials that were most useful for field worker and most suitable for training were: 1) the Field Worker's Manual; 2) IEC material for field work; 3) the lessons plans for the sessions; 4) the participant study material; and 5) the training and audio-visual aids. The training method used most was often was adult learning (33.3 percent). Before and after the training they were given a knowledge test. The results of the pre-test were 55.8 percent and the post test was 71.1 percent.

The number of speakers in the training ranged between 3-7 people who come from various related institutions. Besides this there was provincial level training for the PPLKB from all of the Level II areas (regencies). And similarly, training was held at the regency, subdistrict and village levels.

Contraceptive Distribution System. The current distribution system, i.e., the system that is used normally, is the BKKBN channel. The contraceptive which is distributed is the pill (program contraceptive). Pills that originate at the regency level are distributed to the

Health Centers at the subdistrict level. From the subdistrict they are distributed to villages though the PPLKB/PLKB which then provide them to the PPKBD.

At the RW/RT level the pills are distributed to the SubPPKBD and FP acceptor groups. The contraceptives are distributed by the PPKBD/SubPPKBD at no charge to acceptors who cannot afford to buy them, and at a service fee that ranges between Rp 150-Rp 750 for those who can afford to pay.

Community Funding. The community funding activity was only found in 8 of the 30 areas surveyed. This activity was founded in 1991, the members are those in the RT/RW who have become FP acceptors. The number of members is around 16-30 people. The sources of funds are from members' contributions, service fees for delivering injectable contraceptives, and pill sales. Types of expenditure are, among others, for health services, contraceptive purchases, cadre operational activities, consumption (food), and uniforms. The accounting system: all activities are recorded and always kept up to date by the Chief of the FP Post. From time to time it is checked by the PLKB.

Conclusion

Of the seven main activities, all have been executed according to the program plan. The result of the CBD training has been to increase the knowledge of the training participants. But in practice it is still lacking. This is because it's better that the curriculum matches the conditions in the field. The training plan should involve the PLKB, and there is too little field practice, keep in mind that the training is more like an orientation of one day.

The distribution system that was created still uses the government channels, and the contraceptives that are available also are still government contraceptives. Private contraceptive distribution has shown positive results but the percentage is still relatively small. This is because private contraceptive users can buy contraceptives themselves from pharmacies/drug stores and there are not too many acceptors who use such private contraceptives as pills (the pills in circulation are BKKBN pills).

There are very few community funds, and those that are active are even fewer, percentagewise. This is because the worker's knowledge about funding systems is lacking. At the same time, the active Community Fund groups still depend only on member contributions, the total of which is not very large (pill acceptors, which are gradually declining). Besides, the contributions are not sufficient, so that the funds that are collected are unlikely to grow enough to meet the various FP needs.

The IEC material which was developed is quite good, but there are still weaknesses. Brochure/leaflets on FP have been received by almost all respondents, but the information on Gold Circle is very limited. The worker's knowledge about *KB Mandiri* is better because they have received training and materials, so that it is easier for them to disseminate that information.

MKET promotion has been effective in increasing ELCO awareness, but its acceptance is not yet effective. The proof of this is that the majority of them have never heard of MKET, but they know the different types of MKET methods. This is also supported by the suggestions of the field workers to use more effective methods.

The execution of referrals to the private sector for FP services by FP workers is not yet running well, because the workers (SubPPKBD) have never been given the referral procedure and have never received IEC materials about making referrals to private doctors and midwives. Besides this, a few of the field workers stated that there were no private providers in the area that could be reached easily by the ELCOs.

While the contraceptive delivery service mechanism has operated well. This is because the community is already aware of the need to become self-sufficient in and they also have the means to able to pay, even though not fully.

Recommendations

The general the recommendation to be made is that the training for SubPPKBD needs to be redone because there are still SubPPKBD who have not received *KB Mandiri* training. And the orientation training needs to place more stress on improving skills. For areas which have no facilities for private providers it is better to place a village midwife there so as to develop FP self-sufficiency. Besides that the supply and ease of obtaining contraceptives has to be guaranteed. MKET promotion needs to be intensified, both by the SubPPKBDs and other FP workers, by encouraging them to use the IEC materials for FP counseling as they have already been trained to do. In order to motivate the cadres and FP field workers to refer clients to private providers, there should be a return to the payment of incentives by the private providers to the SubPPKBD and other FP workers. To make the community funds effective, it's better that they be integrated into one fund such as the health fund that is generally managed by the Health Posts. A certain percentage can be set aside from this fund to buy commercial contraceptives as well as other FP services or general health products.

19. Evaluation: CBD, Central Java (4/95)

CBD Evaluation Team, Central Java. *"Program Evaluation: Community Based Distribution (CBD)."* Department of Communications, University Deponegoro, Semarang and The Institute for Mass Communications Research and Development, Jakarta. Semarang, April 1995.

Topic of study: **CBD, *KB Mandiri***	Language of original report: **Indonesian**
Type study: **Evaluation**	Location of report: **BIPIM**
Duration of study: **November 1994-March 1995**	File name of report: **NA**
Location of study: **Central Java**	Date of report: **April 1995**
Study Director: **Tandiyo Pradekso**	Funding: **PSFP**
Technical assistance: **PSG**	Summary prepared by: **Nurfina Bachtiar**

Background

This survey is one of eight evaluations carried out in other provinces which also have the CBD program. The CBD program comes under the PSFP project. The objective of this evaluation is to see how effective the CBD program has been and how much impact it has had on *KB Mandiri* (self-sufficiency). The CBD program in Central Java was carried out in all 35 regencies. The evaluation was carried out in 10 regencies, 28 subdistricts and 30 village clusters. The total number of respondents was 420 people, broken down as follows: 210 ELCOs, 210 FP workers (SubPPKBD) and in-depth interviews with key informants in the 30 selected cluster areas, about training, contraceptive distribution systems and community funding.

Results

Activities. During the two years of program execution (1991/1992-1992/1993), training was also carried out for 504 PPLKB, 3,535 PLKB, 504 Camat, 8,467 Cadres, 8,567 PPKBD, and 50,802 SubPPKBD/Cadres. Total personnel trained was 72,797. All activities of the CBD program were performed according to plan.

Active participants. This evaluation survey was performed in November 1994. Active FP users was 89 percent of all ELCO. The IUD was the most preferred method, used by 36.4 percent of those active participants. The source of contraceptives was 40.6 from the private sector and 58.8 percent still using the government sector. Active participants who paid for their FP service reached 57.2 percent, and what stands out is that 29 percent have the ability to pay Rp 3,000. These ELCO know the FP workers in their areas (83.3 percent), and 57 percent had been contacted by them in the past three months. With respect to IEC, 81 percent of the ELCO have ever seen/heard of Blue Circle and 35.7 percent know its correct meaning. Similarly, 81.9 percent have ever heard about *KB Mandiri* and 60 percent knew its correct meaning. For Gold Circle, only 39 percent have ever heard of it and only 8 percent knew what it meant.

The composition of ELCO respondents who aware of MKET is quite good at 54.3 percent, and an average 44.7 percent already know one or more types of MKET contraceptives. Also, 48.6 percent of ELCOs said that their FP worker had suggested that they use MKET.

Most ELCOs (79.6 percent) said that private sector services, that is from private doctors and midwives, is available in their areas. Those who have ever visited a private provider was 55.7 percent. This is related to the role of PPKBD/SubPPKBD as referral agents, as 53 percent of the ELCOs said a FP worker had suggested that they go a private sector provider.

ELCO have also been offered delivery of contraceptives to their homes by PPKBD/SubPPKBD (29.5 percent). And 17.6 percent have received contraceptives from those workers. Of the ELCOs who received contraceptives this way, 27 percent paid a delivery fee to the worker. The fee varied from Rp 500 - Rp 2000.

According to ELCO respondents, 44.8 percent of the communities have a FP community funding activity, and 39.5 percent became member of the fund. A little over one-third (37.6 percent) made contributions in the form of money and goods. Some of them provided Rp 100 each month (19 percent).

Field Workers. In this evaluation survey the field worker is the SubPPKBD. The majority (89 percent) cover one RW. The number of ELCOs who are under the SubPPKBD's supervision varied between 1-427. The largest number of people who are supervised by a SubPPKBD is 50-100 ELCO (37 percent). The SubPPKBD's knowledge about *KB Mandiri* is quite good, 62 percent already knew the correct meaning, this is because 78.6 percent have had training on *KB Mandiri*, and 75 percent have received IEC material on *KB Mandiri*. Those who have ever heard about MKET is very high (97.6 percent) and 81 percent have been given IEC material on MKET. Over half, 58.6 percent say that they have referred ELCOs for private sector services, and 60.5 percent have gotten material on referrals to private doctors and midwives. The money collected by the SubPPKBD for delivering contraceptives to users' homes is returned to their FP acceptor group. Less than half (40.5 percent) of FP field workers have received IEC on community funding and the one which is interesting is hat 66.2 percent of them have informed the community in their work area about this funding system.

CBD Training. From the 30 villages/clusters surveyed, 28 stated that they have received training. The type of worker trained varied, i.e., they include PPKBD, SubPPKBD and cadre. The largest number of participants trained in an area ranged from 150 PPKBD, to 293 SubPPKBD 293 and 586 cadres. The majority had received the training materials, such as schedules, training items, and IEC material. The most needed training topics were: the *KB Mandiri* movement, Family Welfare, *KB Mandiri* Contraceptive Services, Recording and Reporting, and Promotion of MKET. The value of the training material, such as training plans, teaching aids, manuals and IEC material, all of them, according to the informants, have been used, are suitable and clear as well as useful for the workers. Almost always the training method used was adult learning. Training at the provincial level was attended by the PPLKB and PLKB. The same training material, teaching methods and IEC material were provided in the field worker training.

Contraceptive Distribution System. The majority of the distribution systems in the survey areas reached the RT level. This system is still using government contraceptives, only few distribute private contraceptives. However, what is interesting here is that although the contraceptives distributed are government contraceptives, they collected money for them like a service fee. This happened from the regency to the acceptor level.

But 75.9 percent of the informants stated that the price found in the community is still affordable.

Community Funding. With respect to community funding activities in the survey area, 22 community funds were established between 1989-1996. The majority of them were managed by Chiefs of FP Posts. Most of the members of the fund are from the local RT membership, the local FP acceptor groups, or other related groups. Membership ranges from <15-50> per group, with the majority (54.5 percent) having 50 or more members. Income for the fund generally comes from member contributions. These range from Rp 50-Rp 2,200. The majority of expenditures are for health and FP services, but money is also used to purchase contraceptives. The accounting system, according to most of the informants, is checked by the PLKB and the head of the every month.

Conclusions

The CBD program in Central Java has been carried out according to what was planned. In training, the curriculum follows what is important in the program. In general the distribution system reaches all the way to the RT level. But if the type of contraceptives and the distributors are examined, the majority still use government contraceptives. The community funds exist in almost all areas surveyed. About half of the money is used for health and FP service needs. IEC materials, such as IEC material for *KB Mandiri*, MKET, Community Funding and Referrals, have been provided, although there are still few areas that have not received them. MKET promotion has not fully reached the ELCOs who make up the sample of the evaluation. Referrals to the private sectors have already been made by the field workers, the proof of which can be seen in the ELCOs who have ever made visits to private doctors and midwives. The contraceptive delivery service has been carried out reasonably well, although the number served by the worker is still very low.

Recommendations

Cadres, as the front line workers in the execution of CBD or other FP programs, need to have persuasive skills, motivation, and promotion to be able to encourage the community as much as possible to become acceptors moving toward self-sufficiency. For this purpose, intensive training is needed to improve their knowledge, vision and skills about the FP program. From another angle, one must think of providing better incentives and facilities to increase their motivation. The contraceptive distribution system must be designed so that the private distributor can reach the cadre in the RW or village directly, without going through too many long steps. Indeed, if possible, the distributor could use the cadre as their salesperson. In order to make the community fund more give more importance to FP, a special organization could be formed to manage the money for purchasing contraceptives, or a linkage could be made with another funding institution that is already in the village (such as an *arisan* or *PKK*). Supervision of the community funding effort needs to be increased, especially in the management organization or the management of the community fund.

20. Evaluation: CBD, East Java (7/95)

CBD Evaluation Team, East Java. *"Program Evaluation: Community Based Distribution (CBD)."* Department of Communications, Airlangga University, Surabaya and The Institute for Mass Communications Research and Development, Jakarta. Surabaya, July 1995.

Topic of study: **CBD, *KB Mandiri***	Language of original report: **Indonesian**
Type study: **Evaluation**	Location of report: **BIPIM**
Duration of study: **November 1994-March 1995**	File name of report: **NA**
Location of study: **East Java**	Date of report: **July 1995**
Study Director: **Autun**	Funding: **PSFP**
Technical assistance: **PSG**	Summary prepared by: **Nurfina Bachtiar**

Background

This survey is one of eight evaluations carried out in different provinces. This evaluation survey was undertaken to find out how effective the CBD component of the PSFP project was. In East Java the CBD activity was carried out in 37 regencies/municipality. The survey was conducted in 26 regencies, from which were selected 30 subdistrict and 30 clusters. The total number of respondents interviewed was 420 respondents and in-depth interviews were performed in the same 30 clusters from key informants about: training, contraceptive distribution systems, and community funding.

Results

Activities. The CBD program was executed in the fiscal years 1991/92-92/93 in all 37 regencies in East Java. During this period training was conducted for 588 PPLKB, 4,142 PLKB 645 Camat, 6,170 Cadres, 7,967 PPKBD, and 68,430 SubPPKBD/cadre. The total number trained was 87,942 workers. The other CBD activities were all carried out according to plan.

Active Participants. The survey, which was conducted in November 1994, found that the active FP participants had reached 93.3 percent. Among them 46 percent used MKET contraceptives, in particular the IUD (30.6 percent). Almost half of the active participants got their services from the private sector (45.3 percent). In obtaining those contraceptives, 73 percent of them paid. Among them, 10.4 percent paid more than Rp 7000, while 74 percent paid less than Rp 1,000. Eighty-two percent of ELCOs were aware of and knew the name of the FP workers in their areas, and 51 percent had been contacted/visited by those FP workers. Most ELCOs had seen/heard of Blue Circle (84 percent) and 57 percent know its meaning. For *KB Mandiri*, 84 percent have heard of it and 59.5 percent know its meaning. For Gold Circle, only 39 percent had heard/seen it and only 15.7 percent knew its meaning.

The information about MKET is quite good in the survey area, 73.8 percent of the ELCOs have heard about MKET and an average of 50 percent know the type of MKET contraceptives. Although only 41.4 percent said that the FP workers suggested that they change to an MKET method.

According to the ELCOs interviewed, 62 percent said that private sector doctors and midwives are available in their areas, and 54.3 percent of ELCO said that they have visited

private providers for the FP needs. On the other hand, only 43 percent of the workers suggested that the ELCOs start going to private providers.

One of the FP services provided by FP workers (PPKBD/SubPPKBD) is the resupply of contraceptives. Thirty-one percent have ever been visited by those FP workers and 25.7 percent were offered pills. For this pill service, 14.7 percent of the ELCOs have paid service fees, the amount of which varied greatly.

Community funding was developed to help increase rural *KB Mandiri*. According to ELCOs, the 32 percent of the villages have community funds. Already 23.3 percent of the ELCOs are members of a fund, and 22.3 percent have made a contribution to the fund. The amount of the fee/contribution varied between Rp 1,000 - Rp 5,000.

Field Workers. Field workers in this survey are PPKBD and SubPPKBD. Most of the workers (83.3 percent) cover from 1 to 3 RWs. The number of ELCOs covered by each worker is fairly large, 77 percent supervise 200 ELCOs. All FP workers are aware of the correct meaning of *KB Mandiri*, only 3.8 percent do not know the correct meaning. Only 80.5 percent have had CBD training and 73.8 percent have received IEC materials on *KB Mandiri*, 79.5 percent have heard of MKET and an average of 67 percent know the types of MKET contraceptives, 71 percent have received IEC material on MKET.

In respect to referring ELCOs to private sector providers, 47.6 percent of the workers said that they have referred while 64.3 percent have received a manual on referrals. The contraceptive delivery service activities have been carried out by FP workers, because 58.6 percent have received IEC materials on this service. Almost half of the workers (48.6 percent) offered to deliver contraceptives to acceptors and what was offered most are pills (35 percent). Money received from the service was used for different purposes: 47 percent returned it to the group, 33.8 percent used it to buy commercial contraceptives and 19 percent for reimbursing their transportation. The majority of the field workers (55.7 percent) said that they informed ELCOs about community funding. The same number (54.3 percent) said that they had received some materials about funds but only 36.2 percent had received IEC materials on community funding. However, only 27 percent said that they had developed funds.

CBD Training. The number of participants in CBD training ranged from 17-630 per subdistrict. This training is divided into two parts. Training at the province level (the PPLKB were called to the province) and at the regency level and below. At the regency level and below, an average of 84.4 percent received schedules, training materials, and IEC materials. There are five topics that the workers said they most need training in: the *KB Mandiri* Movement, IEC for *KB Mandiri*, the *KB Mandiri* Process Mechanism, the Role of FP Workers in the CBD program, The CBD Operational Plan. The training method used most often is Adult Learning (40 percent). Meanwhile, at province level, the objective is to train FP workers at the regency/municipality level who then will train the FP workers at the lower levels. The training materials provided are: training plans, curricula, IEC materials, monitoring reports. The time allocated for each session is 45 minutes. The topics most needed are the same as the ones needed at the regency/municipality level. Pre-tests and post-tests were carried out in this province; 60 points before and 80 points after training.

Contraceptive Distribution System. The distribution system in the survey area is varied. The system which distributes government contraceptive is still using the old channels. The interesting thing is that there are distribution models that have been applied to make

possible a private contraceptive channel that can reach to the village level. What can be seen in the model distribution system that has been developed is that there has been very good cooperation between BKKBN, pharmacies and pharmaceutical producers. There are 12 kinds of distribution models, this is because of different geographic and economic conditions, as well as various agreements among the involved institutions.

Community Funding. There are only 12 community funds in the 30 survey areas, all of which were established at the beginning of the CBD program (between 1991-93). From these 12 groups, there are 5 groups with more than 50 members. Sources of funds vary, some of them come from member's contribution, rice funds (jimpitan), and savings and loan funds. Not all of these community funds have an accounting system. Although some do, the majority are not adequate, or in other words, only a few have accounting systems that are working well.

Conclusions

In general, the implementation of the CBD program in East Java can be said to have been done according to plan. Nevertheless, with respect to those things that are more qualitative, there are many problems that will need attention in the future. Among others, the development of community funds, which have experienced many obstacles so that there are only a few funds that are running well, even though almost half of the survey areas have tried to develop them. Field workers who explain *KB Mandiri* are still lacking, as well as those who suggest/promote MKET. Referrals or suggestions by the field workers to use the private sector doctors and midwives are also not intensive enough.

Recommendations

The community funds need to be more intensified and supervised. Management of these community funds needs to be improved through special training, because this has great potential for helping *KB Mandiri* activities. With respect to IEC, the FP workers, that is, the SubPPKBD/Cadre need to improve their knowledge. Perhaps refresher training is needed for these workers. To improve their motivation and dedication, they need to be given some kind of appreciation, such as a financial incentive that might be taken from the community fund. The private distribution system needs to be improved again, because the majority are still dependent on help from the government program.

21. Evaluation: CBD, Bali (6/95)

CBD Evaluation Team, Bali. *"Program Evaluation: Community Based Distribution."* Department of Anthropology, University Udayana Denpasar and The Institute for Mass Communications Research and Development, Jakarta. Denpasar, June 1995.

Topic of study: **CBD, *KB Mandiri***	Language of original report: **Indonesian**
Type study: **Evaluation**	Location of report: **BIPIM**
Duration of study: **November 1994-March 1995**	File name of report: **NA**
Location of study: **Bali**	Date of report: **June 1995**
Study Director: **I. Ketut Suadana**	Funding: **PSFP**
Technical assistance: **PSG**	Summary prepared by: **Nurfina Bachtiar**

Background

This survey is one of eight evaluations carried out in other provinces which also have the CBD program. The CBD program comes under the PSFP project. The objective of this evaluation is to see how effective the CBD program has been and how much impact it has had on *KB Mandiri* (self-sufficiency). The CBD program in Bali was carried out in all nine of the provinces regencies. The evaluation was performed in 6 regencies, 19 subdistrict and 30 villages/clusters. The total number of respondents who were interviewed was 420, as follows: 210 ELCOs, 210 FP workers (SubPPKBD), and in-depth interviews were held with key informants in each of the 30 clusters about training, contraceptive distribution systems and community funding.

Results

Activities. In the CBD program, training was carried out for 60 PPLKB participants, 218 PLKB, 30 Camat, 30 Cadres and 1,720 *Kelian* (SubPPKBD) FP/cadres. The total number who have been trained is 2,088. All activities of the CBD program have been performed according to the planned program.

Active Participants. This evaluation survey was undertaken in November 1994. Active participants who use FP method total 89 percent, from all ELCO. The injectable is the most preferred method(41.2 percent). The sources of contraceptives was 32 percent from the private sector and 66.8 percent are still using the government sector. The active participants who paid for their service reached 77.5 percent. Those who paid above Rp 6,000 are 26.9 percent. Almost of the ELCOs (90 percent) know the names of the FP workers in their areas and 72.2 percent have been contacted by them.

The number of ELCO who have heard of MKET is quite considerable (74.6 percent), and an average of 57.7 percent know types of contraceptive that are MKET.

According to the ELCO respondents, most (80.9 percent) have access to private sector doctors and midwives. The majority (61.7 percent) said that the FP field workers had suggested they use these providers for FP services, and 59.8 percent said that they have visited private sector service providers.

Besides motivation of ELCOs, FP workers are supposed to visit ELCO homes to offer to delivery contraceptives to their homes. About a third (34.9 percent) said they had been

visited by such workers, that they offered pills and condoms, about one-firth (19.6 percent) stated that they received contraceptive from the FP workers and 18.6 percent paid the workers for the delivery service. The amount given varied between less than Rp 500 to Rp 2,000, but the majority (71.8 percent) paid less than < Rp 500.

About 3 out of 5 ELCOs (61.7 percent) said that community fund groups have been founded, and 55.7 percent said that they became members and active. One of the member's obligations is to make contributions to the fund, 35.7 percent have given contributions. Most (80 percent) contributed less than Rp 1,000.

Field Workers. What is meant by "Field Worker" in Bali is the PPKBD, also called *Kelian KB*. In Bali the neighborhood association is known as a *Banjar*. Each *Banjar* is supervised by a *Kelian* who also supervises some ELCOs. Most of the *Kelian* (40.8 percent) supervise 50-100 ELCOs. Their knowledge of *KB Mandiri* is very high, 96 percent understand the correct meaning. Awareness of MKET averages 76.2 percent and 57.2 percent know the types of methods that are MKET. Only 45.6 percent have received IEC materials, however. The success of *KB Mandiri* depends on the *Kelian* suggesting and referring ELCOs to private FP providers for services. About half (52.5 percent) said that they have suggested this to ELCOs and 32.5 percent have actually referred ELCO to private sector services. This low percentage is due to the fact that only 31.6 percent received IEC material on referrals. Fees received from delivering contraceptives to people's homes range between Rp 100 - Rp 1,000. In general the money is returned to their groups, and will then be used to assist ELCOs or members who are not fortunate. Most of the SubPPKBD have an average of 10 steady customers who they provide with pills every month. Although IEC/ information on community funding has been received is very minimal (36.9 percent), this is not an obstacle that keeps them from informing the ELCO about community funds (72.8 percent have informed ELCOs).

CBD Training. A total of 532 *Kelian KB* and Cadres have been trained during the CBD program in the survey areas. Most of them (almost 80 percent) were given such training materials as schedules, teaching aids, and IEC material. The topics they say they most need information about are: *KB Mandiri* Information Distribution, *KB Mandiri* IEC, Recording and Reporting, the *KB Mandiri* Movement. The teaching time of between 15-30 minutes is considered adequate to explain each topic. The majority believe that the training plan, teaching aids, subjects/topics, worker's manual and IEC material for workers are sufficient. All of them have been used, are suitable and clear. The training method used almost always was the adult learning way.

Contraceptive Distribution System. The contraceptive distribution system model development in Bali varied, particularly the distribution of private contraceptive. There has been very good cooperation between the PLKBs and the private doctors and midwives, also between the pharmaceutical distributors and the Health Centers, *Kelurahan* and village clinics. FP workers such as the PPLKB, PLKB, *Kelian KB* play an important role as liaison between the province and the villages/*banjar* in contraceptive distribution. Distribution has already reached 63.3 percent of the RT/*dusun/banjar* level, while 83.3 percent have reached the *kelurahan/desa* level.

Community Funding. From the 30 clusters/*dusun* surveyed, 28 villages stated that they already have a community funding group, most of which are managed by *dusun* chiefs. The membership of each *dusun* differs, and can be divided into three kinds. There are those community associations where everyone in the *dusun/banjar* is a member; or where all

members are FP acceptors, or where the members have a connection with certain groups. The number of members depend on the number of population in that banjar. The largest number of funds (42.9 percent) have more than 71 members.

The source of income is not only from member contributions but also from various social institutions that exist in those *dusun/desa*. The types of expenditures are also varied, and the most prominent one is for FP service in general and contraceptive procurement. All of these community funds have accounting systems, although the recording is very simple. Every month the records are inspected by the head of the fund. According to the local community the fund is very useful and very effective in improving FP service and the health of the village community.

Conclusions

Overall, the conclusion which can be drawn is that the CBD program implemented in Bali has been running well and smoothly, this was proven by the improvement in *KB Mandiri* services. Although there are still weaknesses, nevertheless these can be overcome.

Attention needs to be paid to field worker training topics, they should be limited only to those that are needed. Don't have too many.

There are several types of distribution models which illustrate the creativity and role of social institutions which have participated in supporting the improvement of *KB Mandiri* services.

IEC material is still very limited, so that there are still many workers who do not have them. This has consequences for the informational material that is to be given to the public, especially the ELCOs who are not fully served by the workers (they are not yet providing information in the best way possible).

Regarding MKET promotion, it can be considered as successful in achieving its target. This is because of the cooperation and involvement of the public and the community institutions (*Banjar*).

In the case of referrals to private sector doctors and midwives, it seems that referral material is needed so that the field workers can improve their capability to motivate the community to go to private sector providers.

With regard to the contraceptive distribution service, it is better to charge for it, like a fee for service for the field worker, since in fact in its execution, not much is returned for the group's activities.

Regarding the efforts to set the community funds in motion, it seems to be running very smoothly. The accounting systems still need to be supervised intensively by the relevant parties. These community funds are considered useful and effective for helping ELCOs or acceptors to fulfill their FP needs.

Recommendations

In general the recommendations and suggestions which can be provided are: it necessary to conduct refresher training for the field workers, because the training that they had was very long ago.

This refresher training can take the shape of a change of training method, material or of an evaluation of the workers themselves.

With respect to the development of distribution system, it is hoped that that the field workers will be able to take more advantage of the channels of the social-cultural institutions. The provision of IEC materials need to be improved, in order that all workers receive them. Especially in MKET promotion, the involvement of public figures in promotion is very important. Also the knowledge and capability of workers in developing materials, techniques and referral patterns to private sector providers needs to be improved. Meanwhile, for the contraceptive distribution service, it's necessary to find a way to reward the field workers in accordance with their tasks so as to improve their motivation. With respect to the development of group funds and the collection of community funds, this should be followed by the improvement in the capability of the group to manage that fund. This does not free the responsible institutions from their supervision responsibilities, however.

22. Evaluation: CBD, West, Central and East Java and Bali (3/95)

The Institute for Mass Communications Research and Development, Jakarta. *"Program Evaluation: Community Based Distribution (CBD) in West Java, Central Java, East Java and Bali."* The Institute for Mass Communications Research and Development, Jakarta. March 1995.

Topic of study: **CBD**	Language of original report: **Indonesian**
Type study: **Evaluation**	Location of report: **BIPIM**
Duration of study: **November 1994-March 1995**	File name of report: **NA**
Location of study: **West Java, Central Java, East Java, Bali**	Date of report: **March 1995**
Study Director: **Sasa Djuarsa Sendjaja**	Funding: **PSFP**
Technical assistance: **PSG**	Summary prepared by: **Nurfina Bachtiar**

Background

This survey is a summary of 4 evaluation surveys performed in West Java, Central Java, East Java and Bali where the CBD program was conducted. This program is under the PSFP project. The objective of this evaluation is to see how effective the CBD program was and its impact on FP self-sufficiency. The program was carried out in all of the regencies/municipalities of each of these provinces. The survey was carried out in 30 villages/clusters in each provinces. There were two kinds of respondents, first were 210 ELCO and second were 210 FP workers (PPKBD) in each province. The total number of ELCO from the 4 provinces was 840 respondents. In-depth interviews were undertaken in each province focusing especially on field worker training, contraceptive distribution systems and community funding.

Results

Activities. These four provinces started the CBD program simultaneously between 1991/92 - 1992/93. During this period the four provinces trained 1,823 PPLKB, 11,849 PLKB, 1,850 Camat, 21,772 village chiefs, 25,121 PPKBD and 171,005 PPKBD/SubPPKBD/Cadres, for a total of 270,714 workers. All activities were carried out according to the planned program.

Active Participants. At the time the survey was conducted (March 1995), the number of active FP participants was quite high: West Java 84 percent, Central Java 89 percent, East Java 93.3 percent and Bali 89 percent. The average use of MKET was almost half of the active participants in three provinces: East Java 46 percent, Central Java 58.8 percent, Bali 47.4 percent). Only West Java was lower. One-fourth of the active participants used MKET (27 percent). FP acceptors who have been active more than one year was high in three of the four provinces: West Java 76.7 percent, Central Java 88.2 percent, Bali 79.7 percent. Only East Java was low at 33.7 percent. The source of contraceptive services is still dominated by government/Health Centers (West Java 59 percent, Central Java 58.8 percent, East Java 54.7 percent and Bali 66.9 percent). The private sector was: West Java 32.4 percent, Central Java 40.6 percent, East Java 45.3 percent and Bali 32 percent. Although the domination come from the government service, over 50 percent of active acceptors paid for their services: West Java 77 percent, Central Java 57.2 percent, East Java 73 percent and Bali 77.5 percent. The amount of payment varied among the four provinces from < Rp 1000 to > Rp 5000. The close relation between ELCO and field workers can be seen from the ELCOs' familiarity with the workers' name. On average,

about 75 percent or more are familiar with the name of the workers in their areas. Over a half of ELCO respondents in the four provinces have seen the Blue Circle logo and heard of *KB Mandiri.* For Gold Circle, less than 40 percent had ever heard/seen its logo.

Regarding information about MKET (Most Effective Contraceptive Methods), only 32 percent in West Java and 54.3 percent of ELCO in Central Java know the term. While in East Java and Bali the percentage is high (73.8 and 74.6 respectively). Most of the respondents (except ELCOs in West Java) were actually able to spontaneously specify the types of contraceptives in the MKET category. Almost half of the respondents have been advised to change to MKET by the FP workers, except Bali (60.6 percent).

With respect to the availability of FP services from private doctors and midwives, the midwife services are the most widely available. An average of 30 percent of ELCOs stated that midwives' services are available in their areas. The private sector services have been utilized by ELCOs. About half of the ELCOs surveyed have visited private sector provider. This condition is related to the motivation efforts of FP workers. The ELCOs who said that FP workers suggested that they go to private sector providers was: West Java 36 percent, Central Java 53.3 percent, East Java 42.9 percent and Bali 61.7 percent.

FP worker visits to ELCO houses to deliver contraceptives is not yet very popular. According to the ELCOs, only an average of 29 percent of them (from four provinces) have been visited. And those who received contraceptives from these workers averaged less than a half of the ELCO respondents (West Java 33 percent, Central Java 17.6 percent, East Java 25.2 percent and Bali 19.6 percent). The ELCOs who paid for this service or made an incentive payment made payments in the range of Rp 500 - Rp 2000.

The existence of community funds which are related to FP services, according to the ELCOs in the four provinces, are varied in number. For West Java only 10 percent of the communities have set up funds, Central Java is 44.8 percent, East Java is 31.9 percent and Bali is 61.7 percent.

Field Workers. The field worker here is defined as the PPKBD/SubPPKBD, whose work area usually covers one RW. The number of ELCOs who are under the FP worker's supervision varied between 1-150 ELCO. Field worker knowledge of *KB Mandiri* is far better, generally over 75 percent knew the correct meaning of the term. This is because over half of the respondent have had *KB Mandiri* training (in West Java 46.7 percent have been trained). Also, except for West Java, most have received the *KB Mandiri* IEC material (West Java 3.8 percent, Central Java 75.7 percent, East Java 73.8 percent, Bali 63.1 percent).

The knowledge about MKET is high, over 70 percent of the workers provinces have heard it. Most of them have received MKET materials (West Java 29.5 percent, Central Java 81 percent, East Java 71 percent and Bali 45.6 percent). To increase *KB Mandiri*, the role of worker is very important in referring ELCOs to go to private sector providers. According to the field worker respondents their objective in advising ELCO to switch to the private sector is mostly successful in increasing *KB Mandiri* (West Java 32.4 percent of the workers encouraged their ELCOs to switch, Central Java 46.2 percent, East Java 51 percent and Bali 52.5 percent). Very few FP worker respondents in West Java and Bali received material and IEC on making referrals to the private sector (West Java 27 percent for material and 20.5 percent for IEC, Bali 38.8 percent for material and 31.6 percent for IEC; in Central and East Java over 50 percent of their workers received material and IEC

on referrals). According to the respondents their workers made referrals to the private sector for ELCOs who wanted to obtain private sector services: in West Java 41.9 percent, Central Java 58.6 percent, East Java 47.6 percent and Bali 31.5 percent have referred ELCOs. With respect to the payments for delivering contraceptives to ELCO homes, the FP workers did not charge for the service. It depended on the ELCO or acceptor, as it was strictly voluntary. The incentive received was usually returned to the FP group of interest or given to another community activity. One of the roles expected of the workers is to help form the community fund institution, which eventually is able to assist in purchasing contraceptives for the unfortunate. These workers also received IEC and other material on community funding. In general less than 50 percent have received those materials. The number who informed ELCOs about this funding mechanism varied by province (West Java 19 percent, Central Java 66.2 percent, East Java 55.7 percent and Bali 72.8 percent).

CBD Training. The CBD training in the four provinces took different forms. There was training at the regency, subdistrict or village levels. While the training conducted at the provincial level was for PPLKB and PLKB. Workers who were trained at the province level were expected to train others at the regency, subdistrict and village level. Training materials provided to the participants included: schedules, teaching materials and IEC materials. The curricula included 22 topics, but the most needed were: the *KB Mandiri* movement, *KB Mandiri* IEC, *KB Mandiri* Contraceptive Distribution, Recording and Reporting. The training method used was almost always the adult learning method, while the teaching method used was lecture and question-answer. The demonstration forms used sometimes were role play and small group discussion.

Contraceptive Distribution System. In general the current contraceptive distribution in West Java has already reached the village/*kelurahan* level. In fact, 21 of the subdistricts surveyed have reached the smallest community group, i.e., the RT. In Central Java, the majority of the systems have reached the RT. In East Java the contraceptive distribution systems in 16 of the 30 subdistricts surveyed have reached the RT level, in 7 subdistricts they have reached the village/kelurahan, and the remaining have reached the RW level. In Bali most of the informants stated that the distribution systems dispense to rural areas. In general this system is almost the same from one province to the other, in that at the subdistrict level the Health Centers, PLKB, pharmacy, doctor and midwife are involved.

At the RW/RT level the SubPPKBD, PKB, midwife, doctor, SubPPKBD and *mantri* (doctor's assistant) are all involved. While at the RW/RT level SubPPKBD, PKB RT and Health Post are involved. But besides that another distribution system is found that acts as an alternative to guarantee that contraceptives are distributed smoothly and on time. There is a general picture of the price of contraceptives found in the survey area. For pills the price is between Rp 150 - Rp 1,750, while the cost for injectables is about Rp 2,500 - Rp 4,000. But there are a number of problems, such as the delay in delivery from the regency level. So this upsets the schedule of the acceptors who have to stick to a schedule for revisits.

Community Funding. The number of community funding groups in the survey area is varied. For West Java there are only 8 groups, Central Java has 22 groups, East Java 12 groups and Bali 28 groups. Most of the groups have between 16-30 members in West Java, 15-50 in Central and East Java, and 15-71 people in Bali. There are no complicated requirements in becoming a member of a community fund. One only has to be a member of a local community association, a FP acceptor or an ELCO. Besides this, one has to pay a monthly contribution. All of the community funding groups/institutions in Central Java

actually have a management team (100 percent), in Bali 96.4 percent have such teams. The group's income comes from various sources, both in the form of money and in-kind contributions such as rice or animals. Monthly contributions collected are around Rp 50 - Rp 2,200. While assistance from donors is generally quite large. The expenditures are for health services, FP services, the purchase of contraceptives, loans to members, and drug purchases.

Conclusions

Field Worker Training: Almost all areas have conducted training from the provincial level, to the regency, subdistrict and village levels. The curriculum that has been compiled is in accordance with the CBD program and what is needed by the participants. In general the CBD orientation material provided was clear, suitable for the training, and useful for participants who will then train and apply the materials provided. The training method used was the adult learning method, with such teaching methods as lectures and group discussion followed by question and answer sessions.

Contraceptive Distribution System: In general it has reached the RT Level. But the survey of cadre/SubPPKBD and informants indicates an increase in private contraceptive and private sector service usage. Nevertheless, it can be seen from the type of contraceptives and their distributors that the majority still depend on the government (BKKBN) for both.

Community Funding: Not all of the survey sample areas have community funding groups/institutions. But most of the existing groups in Central Java and Bali function well, while those in East and West Java are not running as they should have been.

IEC material such as for *KB Mandiri*, MKET, referral and community funding in general are suitable for training, and their content is clear and easy to understand. Those materials are suitable for the messages developed, because in fact cadres can provide them to the public. Nevertheless, for various reasons, the distribution of IEC material in some provinces is not being conducted properly. The promotion of MKET has not completely reached the ELCO communities who made up the sample for this survey. There are still many people who do not know about or have not received the MKET information. Referrals to private sector have been made by more than half of the ELCOs. In general they are advised by the FP workers. The trend of the contraceptive distribution service provided by the FP workers is not yet optimal.

Recommendations

The SubPPKBD/cadre, as the implementer of the CBD program, needs persuasion and salepersonship skills to be able to influence as many acceptors as possible to move toward *KB Mandiri*. For this, intensive training is needed for the selected candidates. On the other hand, to improve the cadre's motivation, it seems that better incentives and conveniences should be considered. To maintain and improve FP worker performance in the execution of CBD, therefore, the training should be conducted continuously or refresher training should be given periodically. The contraceptive delivery service is to assure the availability and the ease obtaining contraceptives so as to attract and keep *KB Mandiri* acceptors. For this purpose it would be much better if the contraceptive distribution system were made in such a way so that the private contraceptive distributors can directly reach the rural areas without having to go through too many and too lengthy

steps. And coordination is also needed of the FP workers at the regency/subdistrict/village levels to assure the smooth and appropriate distribution of contraceptives.

With respect to increasing the community funds in order to raise the importance of FP, besides forming a special institution to manage the funds so that the importance of purchasing contraceptives is increased, the funds can also be involved with/united with other fund institutions found in the community. There need to improve the supervision of the community funding effort, especially in the field of management or community funding management.

23. Evaluation: CBD, North Sumatera (3/95)

CBD Evaluation Team, North Sumatera. *"Program Evaluation: Community Based Distribution (CBD)."* Department of Communications, University of North Sumatera, Medan and The Institute for Mass Communications Research and Development, Jakarta. Medan, August 1995.

Topic of study: **CBD, *KB Mandiri***	Language of original report: **Indonesian**
Type study: **Evaluation**	Location of report: **BIPIM**
Duration of study: **April-August 1995**	File name of report: **NA**
Location of study: **North Sumatera**	Date of report: **August 1995**
Study Director: **Safrin**	Funding: **PSFP**
Technical assistance: **PSG**	Summary prepared by: **Nurfina Bachtiar**

Background

This survey is one of eight evaluations carried out in other provinces which also have the CBD program. The CBD program comes under the PSFP project. The objective of this evaluation is to see how effective the CBD program has been and how much impact it has had on *KB Mandiri* (self-sufficiency). In North Sumatera the CBD program was conducted in 17 regencies/municipalities. This evaluation was carried out in 13 regencies/municipalities, which included 30 villages/clusters in 30 subdistricts. There are two types of respondents of this survey: first is 210 ELCO respondents and the second is 210 FP workers, i.e., the PPKBD/SubPPKBD. In-depth interviews were conducted especially for this study on field worker training, contraceptive distribution systems and community funding.

Results

Activities. During 1992-1994 the CBD program in North Sumatera has provided training to 223 PPLKB, 223 PLKB, 223 Camat, 5,636 Village Chiefs 5,636 PPKBD and 19,981 PPKBD/SubPPKBD/Cadre, making a total of 31,922 FP workers. All other CBD activities were performed according to the planned program.

Active Participants. At the time the survey was carried out (March 1995), 74.8 percent of the ELCOs were active FP participants, and 33.1 percent were using long term methods. However, the percentage of pill users was the highest among active acceptors (34.4 percent). The FP service source: 25.4 percent were from the private sector. Over two-thirds (68.8 percent) of the active participants paid for their services (government or private). Most of them(81.4 percent) were aware of or had seen the Blue Circle logo, but only 49.5 percent knew what it meant. Also 80.5 percent had heard of *KB Mandiri* and 65.7 percent knew its meaning. Knowledge of Gold Circle was only 27.1 percent and only 10 percent understood the meaning of Gold Circle (although even those were not absolutely correct).

Only 43.3 percent knew the meaning of MKET. In general, only 33.2 percent, on average, knew the types of contraceptives that are MKET.

Regarding the availability of private sector FP services, 51.9 percent said that there were private doctors and midwives in their area. And those who have visited private sector

providers for FP services was 35.2 percent. Field workers who had advised the participants to use the private sector was 33.3 percent. This means that ELCO awareness toward making visits to the private sector and suggestion from the FP worker to do so, are not bad.

The contraceptive delivery service is related to the offering of contraceptives by the FP workers. Fifty percent of the ELCOs stated that they had been offered contraceptives by the worker. The contraceptive that is offered most is the pill (74.3 percent) and 43.8 percent of the ELCO respondents have received contraceptives from the workers. Of those, 28 percent gave the worker a fee or incentive. The amount provided varied from less than Rp 1,000 to 5,000.

The concept of the community fund is to collect money from the community in order to obtain various kinds of family planning activities. Only 23.8 percent said there was a community funding activity, of these only 16.6 percent and 15.7 percent said that they provided contributions. The amount of this contribution varied between < Rp 500 - Rp 1000 monthly.

Field Workers. The field worker here is PPKBD/SubPPKBD, whose work area is usually one *dusun* (66 percent). The highest ELCO coverage of a SubPPKBD is 50 ELCO or more (32.5 percent). The workers' knowledge about *KB Mandiri* is very good, i.e., 80.4 percent have very good knowledge about it and 86.6 percent have provided motivation on *KB Mandiri* to ELCOs. The percentage who have heard about MKET is 81.8 percent and 51.7 percent admitted that they have received MKET IEC materials, and 37.8 percent have referred ELCOs to private sector, this is because 47.8 percent said that they have received IEC material on referrals. Very few (20.6 percent) have received material that explains the contraceptive delivery service. This has an influence on the number of FP workers who promote this service to ELCOs, which is about half (49.8 percent). Only 20.6 percent of the workers have received IEC material on the community funding program, but 30.1 percent have discussed this program with ELCOs.

CBD Training. The training participants in the survey area are the PPKBD/SubPPKBD/Cadre. All of these participants were trained at the subdistrict/village level. While at the provincial level the training was also conducted for the PPLKB and PLKB. The number of participants per group at the subdistrict/village was about 4 -119 people. All of the participants received the training materials, such as schedules and IEC materials. According to the informants there are three topics which the field workers needed most: the *KB Mandiri* Movement, Contraceptive Delivery Service, and Recording and Reporting. More than a half of the participants stated that the teaching material was suitable for this training and clear. The training method most often used was the adult learning method, while the teaching method used was mostly lectures.

Contraceptive Distribution System. The development of the contraceptive distribution system in North Sumatera has already reached the lowest village community group, i.e., *lingkungan/dusun*, or village. The distribution model that is most effective is the conventional one the (the government contraceptive distribution system). This was the opinion given by more than half of the informants. To distribute the injectable and IUD the Health Center doctor and midwife channel is used. Although most of the contraceptive that are available are the government ones, nevertheless, the acceptors who use them have to

pay. According to the informants, the payments, or price of the contraceptives, is still within reach of the rural community.

Community Funding. Community funds are only found in seven of the survey areas. These funds had been in existence for 1-4 years. Most are managed by the Chiefs of the FP Post. Membership is made up of all of the citizens of the area or there are also groups that are made up of members who are FP acceptors. The total number of members varies between 15 and 50 people or more, but the majority have more than 50 members. The income of these seven funding groups comes from their members' monthly contributions. They provide contribution ranging from Rp 100 - Rp 10,000. All members of this group have made contributions in the form of money. Most of the groups' expenses are for health services and loans to members.

All of these groups have an accounting system, which is always updated, and the majority of those systems are inspected by the village chiefs.

Conclusions

The CBD training has been attended by almost all FP workers in the villages surveyed. The curriculum has been arranged according to the training objectives, among the various topics, there are three which are considered very much needed. The distribution system is running smoothly down to the village level but it is still the conventional channel, which is the government channel. The contraceptives that are available are also the government ones. This means that the private contraceptives are not reaching the village level. There are very few community funds that are established. The percentage who have received materials is also very small. Not all workers have received them. Especially the promotion of MKET has not reached all of the ELCOs, even though the percentage of FP workers who have heard MKET is 81.8 percent. Referrals to private sector have been made, although very few have gone to the private doctors and midwives for services. With respect to the contraceptive delivery service, there is no information about the amount received by the workers, but the activity is being carried out, although the contraceptives that are offered are still from the government.

Recommendations

Cadres as the spearhead of successful CBD programs, need certain skills to carry out their duties. Therefore intensive training is needed, supported by IEC materials which can be used as manuals for them in conducting their jobs. The contraceptive distribution system requires coordination beginning from the 2nd level to the *lingkungan* (SubPPKBD). Besides it is time for private distributors to sell contraceptives directly to ELCOs through cadre at the village level and *lingkungan/dusun*.

To increase cadre's motivation, it is time to consider providing incentives both in the form of money and work facilities as well as providing a profit margin from monthly contraceptive sales.

The CBD program needs to be continued through full interventions and well planned activities, particularly in areas where CBD or *KB Mandiri* achievement is still low.

24. Evaluation: CBD, South Sumatera (8/95)

CBD Evaluation Team, South Sumatera. *"Program Evaluation: Community Based Distribution (CBD)."* CBD Evaluation Team, South Sumatera and The Institute for Mass Communications Research and Development, Jakarta. Palembang, August 1995.

Topic of study: **CBD, *KB Mandiri***	Language of original report: **Indonesian**
Type study: **Evaluation**	Location of report: **BIPIM**
Duration of study: **April-August 1995**	File name of report: **NA**
Location of study: **South Sumatera**	Date of report: **August 1995**
Study Director: **Retna Mahriani**	Funding: **PSFP**
Technical assistance: **PSG**	Summary prepared by: **Nurfina Bachtiar**

Background

This survey is one of eight evaluations carried out in other provinces which also have the CBD program. The CBD program comes under the PSFP project. The objective of this evaluation is to see how effective the CBD program has been and how much impact it has had on *KB Mandiri* (self-sufficiency). In South Sumatera the CBD program was executed in all 10 of the provinces regencies/municipalities. This evaluation was also conducted in all 10 regencies by selecting 30 subdistricts and 30 villages/clusters. The total number of respondents interviewed was 420, and in-depth interviews of key informants were carried out in the same 30 clusters about :training, contraceptive distribution, and community funding.

Results

Activities. The CBD program was conducted in fiscal year 1992/93-1993/94 in all 10 regencies in South Sumatera. During that period training was also conducted for 160 PPLKB, 1,601 PLKB, 250 Camat, 2,879 Cadres, 2,879 PPKBD, and 2,879 SubPPKBD/Cadres. The total number of trainees was 10,648 workers. The other CBD activities were executed according to the plan.

Active Participants. When the survey was conducted in April 1995, 79 percent of the ELCOs were active FP participants. Injectable FP participants were the largest group at 28.1 percent, then pills at 21.9 percent. The source of contraceptive procurement through the private channels reached 44 percent, and 63.3 percent of users paid for their contraceptive services. Most of the ELCOs knew their FP worker (77.6 percent. And 36.7 percent had been visited by these workers. Those ELCOs who had heard/seen the Blue Circle logo was 32.4 percent (but not all knew the meaning); *KB Mandiri* was 40.5 percent and Gold Circle was 6.7 percent.

ELCOs who have heard about MKET was only 22.4 percent. Only 18 percent knew the kinds of contraceptives that are MKET.

According to the ELCOs, about 3/4 (75.7 percent) said that private services are available in their villages from doctors and midwives,. Almost half (48.6 percent) said that they have visited those providers. Almost a third (32.9 percent) of the field workers have advised ELCOs to visit the private providers.

FP workers offer to deliver contraceptives to ELCOs at their homes for a fee. They provide resupplies of such contraceptives as pills, condoms and FP tissues. Only a few ELCO respondents (18.6 percent) said that to FP workers who have offered contraceptive to them, and only 15.2 percent have paid a fee for this service. The amount paid was usually less than Rp 1,000.

According to ELCO respondents, only 16.7 percent said that there were community funds in the surveyed areas, and only 11.9 percent said that they had become members. The sources of funds varied, but the majority said they came from member contributions (10.5 percent) of between Rp 500 - >Rp 1,000.

Field Workers. Field workers here are the PPKBD/SubPPKBD. In doing their jobs they supervise an area the size of an RW. In general a worker supervises one RW (46.7 percent) and the number of ELCOs supervised ranges between 1-200 people (80.5 percent). The understanding of *KB Mandiri* among the workers is very good, 82.8 percent knew the correct meaning of the term. Also, 51 percent have received *KB Mandiri* training and 52.4 percent received IEC materials on *KB Mandiri*. Beside that 63.3 percent have heard about MKET, and 52.4 percent know the different kinds of MKET contraceptives. They have also received IEC materials on MKET. Most (87.1 percent) stated that they had motivated ELCOs to use MKET. In the matter of referrals, the main objective of referrals of ELCOs/acceptors according to the workers, is to improve the quality of service (39.5 percent). Only some of these workers (34.8 percent) have received materials on how to make referrals, 31.4 percent have received IEC materials on referrals, and 41 percent said they had experience in making referrals. Only 28.1 percent of the workers have received materials on contraceptive delivery services. And only 20.5 percent have actually offered this service to the ELCOs.

The acidity of offering contraceptive to the ELCO is done by only 20.5 percent of them. Very few workers (7.1 percent) have received IEC materials on community funding, but 35.7 percent have informed ELCOs/public in their own areas about community funding.

CBD Training. The FP field workers trained in this CBD program are the PPKBD, SubPPKBD and cadres. This training was carried out at the village/subdistrict levels. While the training for PPLKB and PLKB was carried out at the province level. The number participants in each subdistrict/village level ranged from 12 to 300 people. The curricula developed, according to the participants, are very useful for achieving success because they fulfill the practical needs of the FP workers. Topics that were needed most are *KB Mandiri* Distribution, Contraceptive Delivery Service, Recording and Reporting, Community Funding, MKET Promotion and *KB Mandiri* IEC. The teaching method used most often was lecture and question-answer at the end of each session.

Contraceptive Distribution System. Coverage of the distribution system has been develop down to the village and *dusun* levels. The current contraceptive distribution system is the conventional one which has actually been in existence for a long time (the village channel, and the contraceptives distributed are the government or program contraceptives). The difference now is that acceptors give a fee or incentive to the workers for bringing them the contraceptives. In other words the public now pays for their FP services. The amount of payment depends on the kind of contraceptive, for pills they give between Rp 200 - Rp 5,000 (per cycle) and for injectables it is Rp 3,000 - Rp 5,000.

Community Funds. According to key informants there are very few community funding institutions/groups that exist especially to manage fund for FP needs.

This is because they assume that the FP is an individual thing, there is no need to have a special institution for it. There are different kinds of management committees now, including the chief of the PKK, the Chief of the dusun/RW. Membership is voluntary, and the members make a monthly monetary contribution which amounts to Rp 100 - Rp 1,000. The majority of the funds have a minimum of 50 members.

Conclusions

The CBD program was carried out according to plan. The impact of this program on *KB Mandiri* is quite meaningful. The public has started providing contributions toward FP services, although not all of them. Gradually the meaning of *KB Mandiri* has been well accepted and this will solidify their attitudes toward FP services in the future. The urging, support and motivation that is made by the FP workers is quite good, and their efforts to provide information about *KB Mandiri* and the available services seems quite good. Beside that, they (field workers) have also been trained and received materials to support their training.

Community funds, which have been developed to support the *KB Mandiri* program, are not yet effective. This is because the public still assumes that FP matters are individualistic. It is also like that with the distribution of private contraceptive, because in the province of South Sumatera there are still areas that are difficult to reach, not to mention villages that are far away from the subdistricts. Indeed there are subdistricts that do not have pharmacies as distributors. Nevertheless to overcome these problems, coordination has already been undertaken with the various institutions that are involved.

Recommendations

Another training is needed for the field workers, especially about *KB Mandiri*, and promoting the FP program. Furthermore, there is a need to considered how the FP services can be made available in rural areas with guaranteed quality. The fee for the contraceptive delivery service needs to be increased, and ways need to be found to motivate the FP workers to disseminate IEC and to offer contraceptives to the public/ELCO. With respect to community funds, there is a need to inform the public how or what the benefits are of creating such groups, so that they will understand and will want to support community fund groups.

25. Evaluation: CBD, Lampung (8/95)

CBD Evaluation Team, Lampung. *"Program Evaluation: Community Based Distribution (CBD)."* Faculty of Social and Political Sciences, Lampung University and The Institute for Mass Communications Research and Development, Jakarta. Lampung, August 1995.

Topic of study: **CBD, *KB Mandiri***	Language of original report: **Indonesian**
Type study: **Evaluation**	Location of report: **BIPIM**
Duration of study: **April-August 1995**	File name of report: **NA**
Location of study: **Lampung**	Date of report: **August 1995**
Study Director: **Nanang Trenggono**	Funding: **PSFP**
Technical assistance: **PSG**	Summary prepared by: **Nurfina Bachtiar**

Background

This survey is one of eight evaluations carried out in other provinces which also have the CBD program. The CBD program comes under the PSFP project. The objective of this evaluation is to see how effective the CBD program has been and how much impact it has had on *KB Mandiri* (self-sufficiency). The CBD program in Lampung was conducted in all five of the provinces regencies. The evaluation was also conducted in all 5 regencies, from which were selected 30 subdistrict and 30 villages/clusters. The total number of respondents interviewed were 420 respondents with the following breakdown: 210 ELCOs and 210 FP workers (SubPPKBD). In-depth interviews of key informants were also conducted in the 30 clusters, about the training, contraceptive distribution systems and community funding.

Results

Activities. In the CBD program between 1992-1994, training was conducted for 140 PPLKB, 260 PLKB, 150 Camat, 900 Cadres, 900 PPKBD and 1,890 SubPPKBD. The total number trained was 4,240 people. All other CBD activities were performed according to the planned program.

Active Participants. At the time of this survey (March 1995), the active participants using FP contraceptives was 85.7 percent of the ELCO respondents., The pill is the method most used (36.1) by these participants. The sources of contraceptives were the private sector (34.3 percent) and the government sector (58.8 percent). All active participants have paid for their FP services, 38.9 percent paid under Rp 500 and 13.9 percent paid more than Rp 5,000. Most of these ELCOs (80.4 percent) are aware of the names of the field workers in their areas and 44.8 percent have been visited by the workers. Most (84.8 percent) have heard the term Blue Circle, 72.9 percent have heard about *KB Mandiri* but only 36.7 percent have heard of Gold Circle. About half of the ELCO respondents (44.8 percent) described the meaning of Blue Circle but not all of them were correct, 44.7 percent gave the meaning of *KB Mandiri* (even though their answers were not completely correct), while 12.4 percent described the meaning of Gold Circle, but all of them were incorrect.

The ELCO respondents who have heard about MKET was only 36.2 percent and an average of 23.3 percent known the kinds of those MKET contraceptives.

According to 61.4 percent of the ELCOs, private sector services are available in the survey areas, and 53.3 percent have visited a private sector provider for their FP services. The majority visited those sectors on their own will (30.9 percent) and 20.9 percent were referred by the FP workers.

The contraceptive delivery service offered by the workers to the FP acceptors includes pills, condoms, and FP tissues. Only 23.8 percent of the ELCOs who were interviewed stated that the have received contraceptives from the FP workers, and 18.6 percent paid a fee or incentive to the workers for delivering the contraceptives. The financial incentives provided were mostly less than Rp 1,000 (14.3 percent).

Only 17.1 percent of the ELCOs stated that there are community funds in the surveyed areas. And 13.8 percent of them have become members. These sources of community funds come from the members' contributions. The average contribution provided is less than Rp 500 (10 percent of the total ELCOs).

Field Workers. The field workers in this survey are the PPKBD/SubPPKBD, the largest group of whom (40 percent) have a work area of more than five RWs.

While the number of ELCOs who are supervised by a worker was around 50-100 ELCOs (29 percent). The workers' knowledge of *KB Mandiri* is quite good, i.e. 79.5 percent know the correct meaning of the term. And 88.6 percent have motivated ELCOs toward *KB Mandiri*. According to 70.4 percent of the workers, there are private sector services in their areas, but actually 60.5 percent of them have not yet referred acceptors to the private sector. The reason for this is that the ELCOs can go directly to private providers and the information on this that the ELCOs have has been clear. The fees collected from the contraceptive delivery service, were not just kept by the workers individually (11 percent), but 22.4 percent returned it to the group. Only 33.3 percent of them have informed ELCOs about community funding.

CBD Training. The CBD training was conducted at the province, regency and subdistrict/village levels. At the province level the training was aimed at the PPLKB and at the regency level the PLKB. Participants at the subdistrict level totaled between 15-573 people. The training was well executed according to the plan. The topics that were needed most were: Recording and Reporting, *KB Mandiri* Management Mechanism, *KB Mandiri* Contraceptive Services, *KB Mandiri* IEC and Contraceptive Distribution Systems. Most of the key informants stated that they used Adult Learning as the teaching technique. The majority used such teaching methods as: lectures, question and answer, and small group discussions. Almost all participants received training materials, such as schedules, teaching material, and IEC materials.

Contraceptive Distribution System. Most of the contraceptive distribution system in the survey areas reached to the *dusun* and village levels. But the majority of contraceptives distributed were government contraceptives. Only a few private contraceptives were distributed, and only half of the key respondents commented that the price of the contraceptive was affordable by the public.

Community Funding. From the 30 villages/clusters surveyed, 12 of them have community funds. Of these, 11 were between 1991-1995. The fund group managers are

the heads of PKK/Health Posts. The majority of the informants said that the members of the fund groups are those who belong to other community groups.

The number of members in the groups ranges between 31-50 people. These sources of fund income comes mostly come from members' contributions. Ten of the 12 funds have accounting systems, and most of the informants said that those systems are always updated.

Conclusions

In general, the conclusions that can be drawn from this study are that actually in the field there is a trend toward self-sufficiency among the rural population. The majority of the ELCOs have paid for the contraceptives they got, although the source is from the government as well as the private sectors. Besides this, with regard to the CBD program activities, the training for the FP field workers has been carried out in accordance with the plan. But the majority of the materials, such as *KB Mandiri* IEC, private sector referral procedures, and community funding, have not been received. The understanding of ELCOs of FP logos indicates that most of them already know about them, but they do not necessarily understand their meaning.

Regarding the contraceptive distribution system, the facts from the field indicate that in general the model distribution system which includes the various types of contraceptive is included within the contraceptive distribution network of the National FP program. With respect to the community fund groups, the use of the money to purchase private FP services and contraceptive is still small in percentage compared to the expenditures for non-FP items.

Recommendations

In the CBD program in Lampung, there are three matters that need to be considered to improve its execution. These three matters are concrete findings from the field:

1. In training, there is a need to consider improving the knowledge of material on the *meaning and definition of KB Mandiri.* To improve the training, increasing the knowledge on material "meaning and Definition of *KB Mandiri*" needs to be considered. This material is needed for all field workers so that they get a clear and precise understanding, since they are the FP workers who come face-to-face directly with the community.

2. To direct both the ELCO acceptors and non-acceptors toward an attitude of full self-sufficiency in FP, a policy is needed to gradually reduce the supply of National FP program contraceptives in the rural areas. In such a distribution system there is a need to guarantee the services, supplies and ease of obtaining contraceptives for the acceptors and to fulfill the KB Mandiri needs.

3. It is clear in the field that the community funds are not functioning optimally to meet the FP needs. Because of that, it is necessary to raise the role of the FP workers to supervise the existing community fund groups so as to better use the money for the family planning needs. The most important thing that is needed is to increase community motivation to establish community funding groups for FP services and activities.

26. Evaluation: CBD, South Sulawesi (9/95)

CBD Evaluation Team, South Sulawesi. *"Program Evaluation: Community Based Distribution (CBD)."* Evaluation Team, University Hasanuddin, Ujung Pandang and The Institute for Mass Communications Research and Development, Jakarta. Ujung Pandang, September 1995.

Topic of study: **CBD, *KB Mandiri***	Language of original report: **Indonesian**
Type study: **Evaluation**	Location of report: **BIPIM**
Duration of study: **April-August 1995**	File name of report: **NA**
Location of study: **South Sulawesi**	Date of report: **September 1995**
Study Director: **Ediyono and Hasrullah**	Funding: **PSFP**
Technical assistance: **PSG**	Summary prepared by: **Nurfina Bachtiar**

Background

This survey is one of eight evaluations carried out in other provinces which also have the CBD program. The CBD program comes under the PSFP project. The objective of this evaluation is to see how effective the CBD program has been and how much impact it has had on *KB Mandiri* (self-sufficiency). In South Sulawesi the program was carried out in 23 regencies/municipalities. The evaluation was conducted in 20 regencies/municipalities which included 30 villages/clusters in 30 subdistricts. There were two types of respondents: first were the 210 ELCOs and second were the 210 FP workers, i.e., the SubPPKBD. In-depth interviews were conducted especially for this study on field worker training, contraceptive distribution systems and community funding.

Results

Activities. During 1992-1994, the CBD program provided training to 183 PPLKB, 980 PLKB, 183 Subdistrict Chiefs, 1,647 Village Chiefs, 1,647 PPKBD and 8,200 PPKBD/SubPPKBD/Cadres, for a total of 12,840 workers. All other CBD activities were conducted according to the arranged program.

Active Participants. At the time of the survey (in March 1995), 79.5 percent of the ELCOs were active FP participants and pill acceptors still had the highest position (49.1 percent). Those who had been FP acceptors for two years was the largest group (31.1 percent). The source of contraceptives was 81 percent still coming from the government and only 10 percent originated from the private sector. Although the major source was the government, 70 percent of these active acceptors said they paid for their services.

The amount paid was between Rp 500 - Rp 5,000. But the majority of them (63.5 percent) paid less than Rp 500. Over 90 percent of them know the field workers and even know the names of those in the surveyed areas, and 61.9 percent of the ELCOs have been visited by the workers during the last three months. Many of the ELCOs (76.2 percent) are aware of/have seen the Blue Circle logo, but only 50.4 percent could explain what its meaning (although not all of them answered correctly). Also 63.3 percent of the ELCOs have heard of *KB Mandiri*, and only 51.4 percent are aware of its meaning. Only 27.6 percent of the ELCOs knew or heard of Gold Circle and very few knew its meaning. Quite a few (59.3 percent) of the ELCOs are aware of the term MKET and, in general (50 percent) understand the types of MKET contraceptives.

According to the ELCOs only 37.2 percent of the areas have private sector FP services available, such as from doctors and midwives. ELCOs who have visited a private sector provider for consultation on FP issues was 35.2 percent. This is also linked to the FP worker's role in advising ELCOs to visit private providers (only 30 percent of the ELCOs said that this was suggested by FP workers). Besides, most private sector services are centralized in the capital city of the regency and not all of these private providers actively offer FP.

The FP workers offer to deliver contraceptives to the ELCOs homes for a fee.. According to the ELCOs, 43.3 percent of them have been offered contraceptives by the workers, mostly pills. And 35.2 percent have received contraceptives from the workers.

The concept of the community fund is to undertake and activity to collect money from the community to obtain various kinds of FP services. Only nine percent of the ELCOs said that they have community funds in their villages. Only 8.6 percent become members and all of them made contributions in their own groups to the fund. The amount of these payments varied ranging from Rp 200 to Rp 1,000 monthly.

Field Workers. The field workers here are the PPKBD/SubPPKBD, whose work areas mostly include 1 -4 RWs. The highest percentage of respondents (27.6 percent) replied that the SubPPKBD is responsible for coverage of 451 - > 500 ELCOs. Their knowledge of *KB Mandiri* is not very good. Less than half of the field worker respondents (43.4 percent), knew the correct meaning of the term. To improve the *KB Mandiri* program, therefore, the role of the FP workers is very important for referring ELCOs to the private doctor and midwife services. Actually, according to 41.1 percent of the workers, there are no private sector providers located in their areas which can be easily accessed by the people. Only 40 percent of the workers have received the materials about referral procedures, also only 30.5 percent received the IEC referral materials, and only 44.3 percent of the workers have made referrals of ELCOs to private sector providers. The workers do not charge the ELCOs/acceptors for delivering contraceptives to them. It is all voluntary.

The contraceptives offered were various brands of pills which come from the PLKB/PPLKB. Less than half of the workers (42.5 percent) have informed ELCOs about the community funding model, and only 40.5 percent have received the materials on it.

CBD Training. From the information gathered in the field, it seems that the CBD training was combined with the FP training. So the CBD training was a part, or component, of the FP training. Also, there were two subdistricts in the sample that did not receive any CBD training. The number of participants in each of the other 28 subdistricts who received training ranged between 9-27. Almost all of them have received the training materials, consisting of schedules, teaching materials and IEC materials. From the topics presented in the curriculum only four were considered to be needed by the field workers: *KB Mandiri* Contraceptive Services, The Role of FP Workers in CBD, Recording and Reporting, and the *KB Mandiri* Contraceptive Distribution System. The training methods used was the Adult Learning method. The training system implemented at the provincial level was similar to the ones conducted at the subdistrict level. The only difference is that at the provincial level the participants were the PPLKB and PLKB.

Contraceptive Distribution System. The majority of the current systems reach the RT level. Field experience shows that the distribution model still uses the government

channels. However, the users have paid around Rp 1,000 - Rp 2,000 for pills (in areas where the economy is more advanced) and Rp 3,000 - Rp 5,000 for injectables. For those people whose economic condition are less advanced, they were able to pay Rp 200 - Rp 1,000 for pills and Rp 1,000 - Rp 3,000 for injectables services.

Community Funds The community funding activities were only found in 9 of the 30 areas surveyed. These fund activities were established between 1992-1994. The members are those who have become FP acceptors in their RW/RT and the people who are members of other community groups. On average each group has 50 members or more. Income for the funds comes from contributions made by the members, from "arisan" and PKK. But the steadiest source is the monthly contribution, which averages between Rp 300 - Rp 500. The total spent for an activity amounts to around Rp 50,000 - Rp 30,000. These expenditures are for financing FP services, health services, contraceptive purchases, drug purchases and short-term loans to members. The accounting system is based on simple entries. The recording is always done and it is updated annually. It is also checked by the PLKB or the regency BKKBN workers when they visit the villages. This is done monthly.

Conclusions

From the seven main activities, all of them have been carried out according to the program that was developed. However, there were two subdistricts where the FP workers did not receive CBD training. Teaching methods like lectures were not very popular. Respondents were fonder of discussion methods (question and answer). The contraceptive distribution systems have reached the lowest level, i.e., the RT. But the contraceptives that are available are still the government ones, although the acceptors have to make financial contributions to obtain contraceptives or FP services. There are very few community funds in existence, even though the potential for their development is very good, because overall the total number of people who have paid is quite large.

In the promotion of MKET, only a few of the FP workers have recommended the use of MKET. This is because they have still not mastered the MKET material very well. The referrals to private sector providers is very closely linked to the existence of private doctors and midwives in the area. A result of this survey shows that that the location of provider services is centralized in the subdistrict capital city. This location is very far for the village population. Because of this, few of these people come for private provider services. The contraceptive delivery service is linked to the degree of activity of the FP workers in offering this service to the community. Thus this activity needs to be improved in order to increase the contraceptive delivery service.

Recommendations

In general the recommendation which can be given is that that the training for SubPPKBDs needs to be continued, in order to improve their knowledge, mainly about *KB Mandiri*. It is hoped that in providing/clarifying the topics, the lecture or speech methods of instruction won't be used. With respect to distribution, once again the ability of the people to pay can be seen, so it is time to develop a private contraceptive distribution system by involving private distributors and institutions/village leaders to make it easier to distribute to acceptors. In the field of community funds, community leaders need to be involved in developing and running these community fund institutions. This is meant to motivate and encourage the community so that the fund agency will operate properly.

27. Evaluation: CBD, Eight Provinces (12/95)

The Institute for Mass Communications Research and Development, Jakarta. *"Evaluation of Community Based Distribution (CBD) in Eight Provinces (West Java, Central Java, East Java, Bali, North Sumatra, South Sumatra, Lampung and South Sulawesi)."* Jakarta, December 1995.

Topic of study: **CBD**	Language of original report: **Indonesian**
Type study: **Evaluation**	Location of report: **BIPIM**
Duration of study: **Noember 1994-August 1995**	File name of report: **NA**
Location of study: **West Java, Central Java, East Java, Bali, North Sumatera, South Sumatera, Lampung, South Sulawesi**	Date of report: **December 1995**
Study Director: **Sasa Djuarsa Sendjaja**	Funding: **PSFP**
Technical assistance: **PSG**	Summary prepared by: **Author**

Background

Community Based Distribution (CBD) is one component of the Private Sector Family Planning (FP) program. There are currently about 150,000 volunteers in 8 provinces (West Java, Central Java, East Java, Bali, Lampung, South Sumatera, North Sumatera, and South Sulawesi) who have undergone a training/orientation program on the implementation of 5 activities to promote family planning self-sufficiency. The five activities include: 1) initiating FP funds within the community; 2) distributing contraceptives for a small fee for delivery; 3) promoting the use of long-term methods (MKET); 4) providing referrals to private sector service providers; and 5) strengthening the local contraceptives distribution system.

The CBD training in West Java, Central Java, East Java, and Bali was completed three years ago. However, the training in the four other provinces Lampung, South Sumatera, North Sumatera, and South Sulawesi was just completed in March 1994.

In general, this evaluation study has three objectives: 1) to asses the effectiveness of the CBD activities and whether they have been functioning as they are expected to; 2) to identify the extent to which the CBD activities have increased self- sufficiency of both the institutions and the community members in FP Program implementation; and 3) to document experiences in the implementation of CBD that may contribute to the future design of the SDES program (Service Delivery Expansion Support).

Specifically, the evaluation study is focused on seven (7) main activities of CBD, namely:

1. **Field Worker Training**: To asses the extent to which the PPKBD/SubPPKBD training has been implemented, the effectiveness and usefulness of the training curriculum and the training material and delivery, and the extent to which the training has improved their FP competence.

2. **Contraceptive Distribution System**: To find out the continuity and effectiveness of the distribution system for pills and condoms (and possibly a number of injections), and the extent to which the system promotes commercial use of services offered by the private sector.

3. **Community Funding**: To identify the level of continuity and effectiveness of community funding; and whether such community funding effectively promotes mixed contraception and the use of private sector services and commercial contraceptives.

4. **IEC Materials**: To identify the extent to which IEC materials have been developed; how they are used and how extensively; and whether the materials serve to convey the messages intended.

5. **MKET Promotion**: To identify the level of increase in the targeted Eligible Couples (PUS) regarding: (1) information on MKET, (2) acceptance of MKET, and (3) use of private sector services for MKET.

6. **Referrals to the Private Sector**: To identify the increase in referrals to the private sector for FP and contraceptive services.

7. **Contraceptive Distribution Services**: To identify the extent to which the service system (delivery of pills and condoms by PPKBD and SubPPKBD to the acceptors with relatively low charges) have been functioning and how they have affected: 1) the use of contraceptive method mix and 2) private sector services.

Methodology

The method of evaluation was essentially a combination between quantitative and qualitative approaches, applying in three types of survey:

1. **ELCO Survey**. In this survey (also named a rapid survey), information was collected from a number of ELCO samples in the selected villages within the study area. Information was collected through interviews using questionnaires. The sampling in each province was drawn from 30 villages that were determined at random. The respondents were married women 15-44 years old. Seven respondents were selected randomly from each selected village. This puts the total samples of ELCO in 8 provinces as: 8 x 30 villages x 7 respondents = 1680 respondents. The respondent selection was made in stages using population to size (PPS) proportionate sampling techniques.

2. **PPKBD/SUB-PPKBD Survey**. This survey was targeted to PPKBD/Sub- PPKBD workers in the selected villages within the study area. Information was collected through semi-structured interviews. The sampled villages for PPKBD/SubPPKBD were also those villages selected as sample villages for the ELCO survey. Seven respondents were chosen form each village. The total number of respondents in 8 provinces was then: 8 x 30 villages x 7 respondents = 1680 respondents. While the ELCO respondents were taken from selected RTs, the PPKBD/SubPPKBD respondents were chosen from the selected RWs/RT.

3. **CBD Activity Survey**. Through this survey information was gathered from a member of key informants in the study locations, beginning from the provincial level through the village level (of the selected villages). Information was collected by means of semi- structured questionnaires, covering three aspects: CBD training, contraception distribution system and, community funds.

Operationally, the information on the three topics was obtained from "key informants" in the sample RWs/villages/ subdistricts. These key informants include the PLKBs, PPKBD and

Sub-PPKBD staff, and informal leaders of community based- institutions such as the FP Participant Groups, midwives, PKK promoters, and other figures.

Findings and Recommendations

Findings

The Community Based Distribution (CBD) component is designed to increase the role of community-based institutions in promoting FP self-sufficiency.

Overall the five activities in CBD program activities have been proceeding as expected, with the exception of community funding. The other four activities have been functioning in all their respects and in a coordinated and programmed manner, and have yield results as expected. However, the community funding activity does not appear to be functioning as planned. The data show that the larger part of the sample villages still do not have community funding programs.

The activities of the CBD program have had a positive impact on self-reliance as well as community participation in the FP program. This has been indicated by the increasing role of PPKBDs and Sub-PPKBDs in promoting the FP self-sufficiency Program, and the increasing number of FP participants using private sector services.

Specifically, the conclusions regarding the 7 aspects evaluated in the study are as follows:

1. Field Worker (PPKBD/Sub-PPKBD) Training

Almost all the sample areas in this study have carried out CBD training. In general, the training takes the form of a one-day orientation program. At the provincial level, such an orientation program comprises one or two training activities designed to get inter-agency agreement on CBD implementation. The other training activity is training for the trainer, that is, training for FP field workers at the municipality/regency level.

The curriculum designed for the CBD orientation did serve the purpose to increase the competence and skills of the cadres in performing their field tasks. The subject matter of the curriculum which are most highly demanded by the participants are those on the FP Self-Sufficiency Movement, Family Welfare, FP Self-Sufficiency Contraception Services, Recording and Reporting, and MKET Promotion.

In general, the materials in the CBD orientation were clearly presented and useful for the participants in carrying out their field activities. The most frequently used training methods were lectures, large group discussions with question and answer sessions.

The CBD orientations have improved the participants' competence in the FP program, in the sense that the orientation was practical for the participants. However, there are a number of deficiencies, namely, the time for the training was insufficient to cover the material presented, the lack of continuity in the training system, the selection of training participants, trainers and materials, and the lack of comprehensive training method touching the psychomotor aspects that improved their skills.

2. Contraceptive Distribution System

In general, the contraceptives distribution system has reached down to the RT level. The survey of the cadres/Sub-PPKBDs and informants shows an increase in the use of commercial contraceptives and private sector services. However, in terms of the provision and distribution, the system is to some extent still depend on the government (BKKBN).

3. Community Funds

Not all the areas evaluated in this study already have community funding institutions for FP purposes. The institutions were generally established in the period of 1986-1993. The majority were found in Central Java and Bali, and they are relatively well functioning. Meanwhile the institutions in West Java, East Java and North Sumatera are not yet running well.

In general, the funds raised in these institutions are used for health services, FP services, saving and lending, and contraceptives purchases. The benefit expected from this funding is to help community members who cannot afford to participate in FP at their own expense. It is also expected to help those members who are in urgent need (being sick), to support the organization's activities, and to assist the members in their productive activities.

4. IEC Materials

IEC materials such as those for self-sufficient FP, MKET, Referrals to the private sector, and Community Funding are in general viewed as suitable for training material, easily understood, and are highly useful for the field workers in carrying out their tasks. However, for one or two reasons, these IEC materials are not available in a number of sample villages.

5. MKET Promotion

MKET promotion has not evenly reached the targeted ELCOs in this study. Many of them have not heard about MKET. This is understandable as not all of the cadres/Sub-PPKBD respondents know MKET. However, the larger part of the Sub-PPKBDs who have undertaken training, have acquired MKET material, and have a good and increasing number of acceptors using MKET in their operational areas. This is an indication that MKET is being well accepted by the PUS.

Despite this, promotion of MKET is still impeded by its being a sensitive and personal issue in the community, involving socioeconomic factors, and the low awareness of the ELCOs concerning the benefits of MKET.

6. Private Sector Referrals

The data collected shows that over one half of the ELCOs have visited or used private doctor/bidan services, and that they in general did it after having been so advised by FP workers officials. The number of ELCOs using private doctors/midwives services is also increasing.

7. Contraceptive Distribution Services

Contraceptive distribution services carried out by the cadres did not seem to proceed as much as desired. This is indicated by the number of respondents who stated they had not been offered contraceptives to buy. This is corroborated consistent with the findings from of the Sub-PPKBD survey which shows that while a good number of them have acquired the materials presented in the training, not many of them have offered contraceptives to the acceptors.

The associated factors may have been that the cadres have only been referring the ELCOs to private doctors/midwives for the purpose of self-sufficient FP, and not all types of contraceptives could be offered to the acceptors.

B. Recommendations

As the success of CBD program is associated with a number of important factors such as the motivation and competence of the cadres, the system and regularity in the distribution of contraceptives, and the coordination between the FP officials at all regency, subdistrict and desa levels, the findings of this evaluation suggest that:

1. The cadres, who are the spearhead in the implementation of CBD, need to have sales skills requires and persuasive ability to motivate the acceptors to become self-sufficient in FP. This suggests the need for intensive training for selected candidates (instead of an orientation for a large number of participants who may not have the required competence). At the same time, in order to motivate the cadres, it is worth considering an offer of incentives and provision of better facilities.

2. To improve the cadre's performance in CBD activities, and to get materials that better serve the field conditions, the training should be conducted on a continuous basis or be supplemented with periodic refreshing sessions.

3. There is a need to maintain contraceptive distribution service, the availability and accessibility of contraception in order to attract new acceptors and maintain the existing acceptors of self-sufficient FP. In these respects is it advisable that the distribution system be arranged in such a way that the (private) distributors can have direct contact with the cadres at the village or RW levels. It is also recommended to use the cadres as salespersons.

4. Also in the distribution system, there is the need for coordination of the FP officials at the regency, subdistrict and desa levels, so as to ensure smooth and timely distribution of contraception, so that the self-sufficient FP acceptors feel more certain of the continuity of their program.

5. To intensify community funding for FP, it is advisable that the existing institution be amalgamated with the present fund raising institutions in the community such as arisan PKK, etc.

6. There is a need to improve the community fund raising program, particularly in management aspects.

28. Referral Pharmacies (12/95)

ISFI. *"Evaluation of the Referral Pharmacies and Village Contraceptive Posts in East Java."* Surabaya, (December) 1995.

Topic of study: **CBD**	Language of original report: **Indonesian**
Type study: **Evaluation**	Location of report: **ISFI**
Duration of study: **April-December 1995**	File name of report: **NA**
Location of study: **East Java**	Date of report: **February 1996**
Study Director: **M. Zainuddin**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Author**

Background

Within the service framework of family planning for rural communities, is the pioneering Referral Pharmacy (AR) and Village Contraceptive Post program (PAKBD). This program has been operational in East Java since 1993. An evaluation of how far the accomplishments meet the needs is needed and the results need to be disseminated to other areas.

Based on the above, a research project was undertaken with the following objectives: to evaluate the effectiveness of the East Java AR/PAKBD program, to identify factors that support and inhibit it, and to document Referral Pharmacies that can serve as successful models. Thus, the output of this evaluation would be a portrait of the East Java AR/PAKBD program and a model AR that can be replicated in other areas.

Methodology

The sample consists of 30 AR, with a minimum of two PAKBD for each AR selected. Stratified, proportional random sampling was used, with the strata being the four Development Areas (Wilayah Pengembangan I-IV). From the 30 AR selected, 2 PAKBD were selected at random, and within each PAKBD 5 family planning acceptors were selected at random. Thus, the total sample consists of 30 AR, 60 PAKBD and 300 acceptors.

Data were collected via structured and open-ended interviews with all AR, PAKBD and acceptor samples. These data were compiled to identify the factors that influenced results or performance of the AR and PAKBD, such as environmental, community, program and marketing factors. In addition, other data were collected on AR/PAKBD indicators that would show to what extent the tasks and functions of the AR/PAKBD were fulfilled.

Conclusions

In general, the AR program of East Java appears to be effective, as seen in most tasks and functions from distribution to reporting. However, management of and IEC for the AR are not yet satisfactory.

The performance of the PAKBD program is good. It is consistent with community needs, promotes distribution, and increases awareness and self-sufficiency among the rural population.

Factors that support the program performance include: the AR leadership of the PAKBD;

coordination between the involved institutions; the legality of the AR/PAKBD program, and financial support.

Nevertheless, there are also inhibiting factors, among which are: the low level of KB Mandiri within the communities; the relatively high price of the contraceptives; the regulation of PAKBD in partial *Mandiri* areas; the low level of awareness and motivation to use the AR and PAKBD; and the continual distribution of program contraceptives.

Recommendations

There is a need to improve: coordination of the AR with the involved institutions, both horizontal and vertical, the management of the PAKBD by the AR, the socialization of people toward the AR/PAKBD program, the quality of the training and IEC materials, the expertise of the FP and KB Mandiri program, and the control of the price of contraceptives.

The PAKBD needs to be compatible with the level of KB Mandiri and the status of the community, especially the village midwife and future PAKBDs that become Village Medicine Posts.

With respect to replication of the AR in other areas, one needs to asses the situation in the selected areas and undertake a test. Thus, a booklet of guidelines is needed on the AR/PAKBD program.

From this summary of research results and recommendations, we conclude that follow-up is needed so that the AR/PAKBD program can improve its performance in the future.

PROFESSIONAL ORGANIZATIONS

29. Mail Survey of IDI Training (11/93)

Reynolds, Jack. *"IDI Private Sector Family Planning Training: Mail Survey Results."* Project Support Group, Private Sector Family Planning Project, BKKBN. Jakarta, November 1993.

Topic of study: **Doctors, Training**	Language of original report: **English**
Type study: **Evaluation**	Location of report: **IDI, USAID, URC, PCS**
Duration of study: **March-November 1993**	File name of report: **IDI_1029**
Location of study: **West Java, Central Java, East Java, Bali, North Sumatera, South Sumatera, Lampung, South Sulawesi**	Date of report: **November 5, 1993**
Study Director: **Jack Reynolds**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Jack Reynolds**

Background and Objectives

Sometime in the spring of 1993 IDI, BKKBN and USAID became concerned that IDI's program to train General Practitioners (GPs) in IUD, Norplant and Counseling skills might not be reaching the appropriate audience. Rather than rely on anecdotal evidence or a large and expensive evaluation, IDI decided to conduct a simple mail survey to determine: 1) who was being trained; 2) whether the trainees were using the skills that they were taught; and 3) whether there had been any increase in their IUD and Norplant caseloads as a result. If the results were positive, IDI would continue with its training program. If not, the training would be ended and another approach developed.

IDI asked the PSG to design the survey, analyze the results and prepare a report. IDI agreed to reproduce and mail out the questionnaires, to do a follow-up mailout, and to send the returned questionnaires to the PSG for processing. In the meantime, further training was to be suspended.

Methodology

The PSG designed a simple two-page questionnaire in April which was pre-tested in May in Surabaya at the IDI provincial office. The instrument was revised, reproduced, and IDI mailed the questionnaire out in June to 800 physicians who had been trained up to that time. PSG prepared a preliminary analysis of 194 questionnaires that had been returned by early September. IDI sent follow-up letters out to the non-respondents and in October another 50 questionnaires were received and sent to PSG. This report summarizes the results of the analysis of all 244 questionnaires received from the project's eight provinces. This represents 31 percent of the total respondents, and is a relatively good response rate for a mail survey.

Results

The results indicate that a significant proportion of the doctors trained (23-41%) did not have private practices, and, therefore, should not even have been selected for the training. Three types of training were offered by IDI: IUD insertion and removal; Norplant insertion and removal; and counseling. The majority of the participants (52.5%) took only one topic, the most popular of which was Norplant (38.9%). About one-third (33.2%) took two

topics, mostly a combination of Norplant and counseling (23%). The rest (14.3%) took all three topics.

The respondents were asked how confident they felt about their skills after completing the IUD and Norplant training. Most (86-96%) felt quite confident in both their ability to insert as well as to remove both the IUD and Norplant capsules.

Pre-post Training Change

An important objective of the training was to increase both the number of providers and the number of clients who sought the services of those providers for IUD and Norplant. The great majority of participants did not insert IUDs either before (78%) or after (68%) training. The total number of IUDs inserted per month was also low. The 90 participants had a total of only 82 insertions before training and 99 after. This works out to an average of about 1 IUD insertion per doctor. Over a one-year period, this group would insert about 1,200 IUDs. The increase due to the training would only be about 200 IUDs per year. The data for IUD removals (before and after training) are similar. The majority of the participants did not remove any IUDs, either before or after training, but there was a small increase in both the number of physicians doing removals and the number of clients served.

The data on Norplant participants also shows that the majority did not do any insertions before (73%) or after (58%) training, but the increase was much larger than for IUDs. The number of physicians inserting Norplant increased from 65 to 86 and the number of insertions increased from 226 to 286 per month. That computes to an annual increase in Norplant insertions of about 720 due to the training. The monthly average for the participants only rose 1 insertion (from 1.1 to 1.9 per month).

The Norplant data for removals are similar to those for insertions. The majority did not remove any of the devices either before or after training, but there was an increase in the number and percentage of physicians doing removals (from 60 to 105, or 29% to 51%). The number of Norplant removals almost tripled, from 128 to 360 per month. This would be about 2,800 additional removals a year due to the training. But again, this is not a very large number overall. The average number of removals for the group is less than 2 per trainee per month.

Reasons for Not Providing Services

Participants who had two or fewer IUD or Norplant clients per month in their private practice were asked why they had so few clients. Two principal reasons were given: 1) not enough demand (43% Norplant, 43% IUD) and 2) not enough equipment (42% Norplant, 50% IUD). On the demand side, the doctors state that there are too few clients who are interested in the service and those who are interested go elsewhere, probably to the Health Center and/or the local bidan. We have also assumed that those who do not provide the service also do not have enough requests.

The other significant constraint is lack of equipment, which probably refers to an OB/GYN bed and OB/GYN equipment, which are necessary for both methods. The doctors also state that Norplant, the contraceptive itself, (but not IUDs) is not available and is too expensive.

Just as important, the doctors did not say that: 1) they lacked the skills to do insertions and removals; and 2) that the procedure takes too much time.

Preferences for Future IDI Training Courses.

All of the doctors were asked to select up to three topics for future IDI training. Most (72%) requested more training. There were four principal topics suggested: 1) how to handle side-effects and complications (69%); 2) refresher training in family planning clinical standards and guidelines (55%); 3) counseling (49%); and 4) client screening and medical examinations (41%). Other topics suggested were client satisfaction, infection prevention, medical record-keeping, and self-assessment.

Epilogue

After discussions with USAID, IDI decided to cancel its family planning training program for private sector, general practice physicians.

30. IDI Clinic Feasibility Study (9/95)

Sudiyono, H. Yono. "Results of the Feasibility Study of Basic Health Services (Level 1) through Private Practice Doctors, General Clinic Doctors and PT Astek." Indonesian Medical Association, Jakarta, September 1995.

Topic of study: **IDI, JPKM**	Language of original report: **Indonesian**
Type study: **Analysis**	Location of report: **IDI**
Duration of study: **March-September 1995**	File name of report: **NA**
Location of study: **West Java, Central Java, East Java, Bali, North Sumatera, South Sumatera, Lampung, South Sulawesi**	Date of report: **September 1995**
Study Director: **H. Yono Sudiyono**	Funding: **PSFP**
Technical assistance: **James R. Marzolf**	Summary prepared by: **Jack Reynolds**

Background

This is a report of a feasibility study of establishing Family Doctor Clinics under contracts to a JPKM company (Jaminan Pemeliharaan Kesehatan Masyarakat) named PT Astek (Asuransi Tenaga Kerja). JPKM is a new health financing system developed by the Department of Health *(Depkes)* to provide universal coverage through enrollment of workers in managed care programs to which they and their employers contribute. IDI was interested in becoming a provider of services for PT Astek. A "situation analysis" was completed to determine if there were enough sites where Astek needed providers and IDI could provide services. Over 80 potential sites were identified and ranked. Those with the greatest potential were chosen for further examination (a feasibility study), with the ultimate objective being to select seven for development.

The paper describes the results of this feasibility study of seven locations in: Ujung Pandang, Surabaya, Kudus, Klaten, Bandung, DKI Jakarta and Medan.

Methodology

Data were collected from providers at these sites, from "contract doctors" (PPK) who were potential candidates to become family doctors in the clinics, from PT Astek offices at each site, from IDI chapters at each site, and from others. The objective was to determine if it would be economically feasible for IDI to operate a clinic in each of these sites. That involved collecting local data on the potential demand for services (number of people in the target population, population characteristics, disease and illness patterns, competition, etc.) as well as the costs of supply (number and type of medical staff, specialists, equipment, facilities, unit costs of basic preventive and curative services, etc.). The third element was to determine the amount of payment (capitation fee) that PT Astek would have to pay to IDI to make it economically feasible for IDI to provide the services to Astek enrollees.

Results

1. In general, there are enough contract doctors available at these sites to provide the services needed for PT Astek enrollees. In addition, about half of these doctors already have a connection with PT Astek.

2. About 97% of the PPK doctors are willing and able to provide JPKM services to PT Astek enrollees.

3. The needs of the enrollees can be met, as there are about 95 PPK in the top eight locations.

4. The capitation needed is not yet set between the providers and PT Astek, and will vary depending on the socio-economic condition of each area. However, it should be between Rp 1,200 and 1.400 per person per month.

5. From these results, seven PPK can be selected and prepared to set up seven IDI comprehensive health clinics to work with PT Astek.

6. A constraint that needs to be dealt with is establishing a connection between the PPK and each local Astek office. Only half of the PPK have such a connection, and their experience is limited.

Recommendations

1. In order to provide adequate services to PT Astek enrollees, the PPK have to be prepared to provide professional health care and to manage their clinics well.

2. PPK who are already prepared and who have a relationship with an established clinic (foundation) need support and continuing education/training from IDI to make sure the services and management are provided professionally.

3. Coordination between PT Astek and IDI should be centralized, and operations should be carried out at each site in accordance with each local situation.

31. Development of IDI Clinics (12/95)

Marzolf, James R. "Development of Family Doctor Clinics by the Indonesian Medical Association to Promote Family Planning through JPKM." University Research Corporation. Jakarta, December 1995.

Topic of study: **IDI, JPKM, Clinics**	Language of original report: **English**
Type study: **Evaluation**	Location of report: **IDI**
Duration of study: **September-December 1995**	File name of report: **NA**
Location of study: **West Java, Central Java, East Java, North Sumatera, South Sumatera, Lampung, South Sulawesi**	Date of report: **December 1995**
Study Director: **James R. Marzolf**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Jack Reynolds**

Background

This is an evaluation of a pilot project to test the feasibility of operating multi-service health clinics, called Family Doctor Clinics, under contract to JPKM (Jaminan Pemeliharaan Kesehatan Masyarakat). JPKM is a new health financing system developed by the Department of Health *(Depkes)* to provide universal coverage through enrollment of workers in managed care programs to which they and their employers contribute. Instead of billing an insurance company for each patient visit, JPKM companies contract with providers and pay them a set amount each month (a capitation fee) in return for guaranteeing to provide the members with the health services agreed upon.

The potential benefits of this strategy for family planning are significant, because FP is included in the "basic benefits package" and must be provided in all JPKM programs at no additional cost to the beneficiaries.[5] This means that JPKM could serve as the vehicle to provide access to FP (and other MCH services) to almost all Indonesians. This is also an excellent way to promote KB Mandiri.

The paper describes in some detail the advantages of this strategy to IDI (as a way to employ "contract doctors"), JPKM companies (as a way to obtain standardized, high-quality medical services), as well as the advantages of IDI-JPKM clinics over such other options as specialized family planning clinics.

The approach adopted for the pilot involved three lines of activity: 1) development of standard administrative systems (MIS, quality assurance, and general administrative); 2) site selection (a general situation analysis, feasibility studies of the top sites, and business plan development for the pilot sites); and 3) implementation (clinic staff training, site preparation, commencement, operations, evaluation). Each of these is described in detail in the report.

Results

The initial plan called for initiation of activities in December 1993 with commencement of operations in July 1994. Significant delays were experienced, due largely to the

[5]. See the National Health Law (UU #23, 1992), the National Worker's Security Law (UU #2, 1992) and related health regulations.

unavailability of dedicated IDI personnel to conduct and monitor the activities. Some activities were not carried out at all, and others were eventually completed by the USAID/URC consultant. In July 1995 a concerted effort was made to complete the developmental work and to open as many clinics as possible before the end of the PSFP project in December. Between September and October all of the technical systems, training and a majority of the business development activities were completed. Three of the seven test clinics opened in October.

The evaluation reports on the status of all seven sites and draws a number of important "lessons" from the two-year experience. The three operational clinics did not develop or follow adequate business plans. As a result, they one or more of four basic problems: 1) overstaffing; 2) excessive procurement of equipment; 3) inappropriate layout of space; and 4) inadequate capitation rates. If these clinics are willing and able to correct these problems, they should become successful enterprises.

Of the remaining four sites, one is no longer operating, another was unsuitable but a more attractive site has been identified, a third site needs to be reconsidered. The fourth site was already operating under an existing JPKM contract and needs to be assessed. It has not yet developed a business plan.

Conclusions

There were several significant problems, the most significant being the lack of dedicated staff at IDI to carry out the pilot test. As a result some activities were not completed correctly (the feasibility analysis, development of business plans, site preparation, in particular) and others were rushed. Instead of a year of implementation of seven clinics there was only time for two months of operation of three clinics. The development of an agreement between IDI and PT Astek (the JPKM company) took two years.

Nevertheless, there were significant "successes" as well. The three technical systems developed are high quality and will be extremely useful in the future. The experience gained has been valuable, and has provided the basis for a more systematic and rational methodology in the future. Late in the project the idea of developing a franchising system arose. A separate report on that provides the basis for organizing and operating clinic development at IDI in a more rational and businesslike manner.

Recommendations

1. Site selection must be made on rational economic criteria.

2. Feasibility studies and business plans must be developed and interpreted correctly.

3. A collaborative agreement between IDI and PT Astek must be negotiated and nurtured. IDI should also make contacts with other JPKM companies.

4. The current clinics are not entirely congruent with the model needed for JPKM implementation. In addition to correcting those deficiencies, IDI needs to develop a "model" clinic in a prominent location, such as Jakarta.

5. Adequate development capital must be secured.

6. The most attractive strategy for the future is the development of the franchising system. It needs to be developed.

7. Significant social marketing needs exist, including the Family Doctor Clinic concept to IDI itself, the JPKM companies, BKKBN, Depkes and the Medical Schools.

32. Development of an IDI Clinic Franchising System (12/95)

Marzolf, James R. *"Development of Franchising System for Promoting Sustainable IDI Family Doctor Clinics."* University Research Corporation. Jakarta, December 1995.

Topic of study: **IDI, JPKM, Clinics**	Language of original report: **English**
Type study: **Analysis**	Location of report: **IDI**
Duration of study: **December 1995**	File name of report: **NA**
Location of study: **National**	Date of report: **December 1995**
Study Director: **James R. Marzolf**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Jack Reynolds**

This report supplements an evaluation of the Family Doctor Clinic concept.[6] It describes a strategy for standardizing the development of such clinics throughout Indonesia by IDI, the Indonesian Medical Association. The clinics would be identical in many respects: appearance, services offered, equipment, layout, staffing, hours of operation, administrative systems, quality standards, and so forth. Potential clients would know, therefore, what to expect from an IDI clinic and IDI would make sure that these expectations were met by the providers.

Nine types of franchises are envisioned, based on three levels of service (standard clinic, silver class, gold class) and three implementation options (build new, refurbish, or convert). IDI would set up a separate IDI franchising company to provide a franchise "package" consisting of such elements as contracting, financial analysis, facility design, procurement, marketing, administrative systems, quality assurance systems, staff training, technical support and capitalization.

A proposed organizational structure and the activities that the organization might carry out are described in the report.

A hypothetical model system is described based on clinics similar those at the three test sites.[7] To set up a "standard" clinic an owner would need to pay an initial fee of $12,000 and an annual fee of $950 to IDI. IDI would reach the break-even point with 11 standard clinics.

An important role for IDI will be helping the franchisees obtain capital. Several suggestions and sources are identified in the report. Concrete steps for proceeding with the development of a franchise system are also laid out.

The prospect for developing IDI Family Doctor Clinics through a franchising system is promising and features manifold advantages, not only for IDI and the franchisees, but for the ambulatory health care system as well. The major challenge will be for IDI to establish and develop the necessary organization to carry the strategy out properly. The requisites are clear and the basic components are specified in this document.

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[6] Marzolf, James R. *"Development of Family Doctor Clinics by the Indonesian Medical Association to Promote Family Planning through JPKM." University Research Corporation. Jakarta, December 1995.*

[7] Ibid.

33. IBI Peer Review: OR Project (12/93)

Karsono, Rosini, et al. *"Final Report of the Peer-Review Operations Research Project: The Feasibility of Establishing a Self-sustaining IBI Peer Review Program to Improve Private Sector Family Planning Services in Indonesia."* University Research Corporation, Jakarta, December 10, 1993.

Topic of study: **IBI, Midwives, Peer Review**	Language of original report: **English**
Type study: **OR**	Location of report: **IBI**
Duration of study: **April 1992 - September 1993**	File name of report: **NA**
Location of study: **Central Java (4 regencies)**	Date of report: **December 19, 1993**
Study Director: **Rosini Karsono**	Funding: **PSFP**
Technical assistance: **PSG, ACNM**	Summary prepared by: **Author**

Background

The Indonesian Midwives Association (IBI) carried out this project between April, 1992 and September, 1993. Peer review was pilot tested in four regencies of Central Java province: Purworejo, Karanganyar, Kudus and Semarang. The American College of Nurse-Midwives (ACNM) and University Research Corporation (URC) provided technical assistance as part of USAID's Private Sector Family Planning project.

The purpose of this project was to develop and test the feasibility of the establishing a self-sustaining peer review program, using peer review (PR) and fundraising (FR) committees within local IBI chapters as a way to improve the quality of family planning (FP) services provided by bidans in private practice in Indonesia.

Findings

1. **Peer review is feasible.** All activities in the PR model can carried out by the PR and FR committees. Yet, some activities such as the development of the PR checklists emphasizing process and the performance of procedures as well as their side effects and complications were found to be time consuming and require considerable training.

2. **Peer review is beneficial.** Peer review is useful as a model of quality assurance, for identifying strengths and weaknesses in performance and addressing these through individual feedback and continuing education for all midwives. BPS, PR and FR committee members, other IBI members, IBI chapters, the midwives' clients and other health care providers all benefits from peer review.

3. **Peer review is probably sustainable if modifications are made in the peer review process.** The fundraising activities are able to support all the costs associated with conducting peer review. Activities will continue to be monitored in Central Java to learn more about long-term sustainability after external technical assistance has stopped. Follow-up is recommended.

Other benefits of the project included the following For the midwives reviewed: each learned which specific aspects of their practice needed improvement, had the opportunity to discuss professional standards with a colleague, and received individual attention related to their practice. For the reviewers: each learned the professional standards in detail; learned

to make systematic, specific assessments; learned to synthesize findings and give feedback about specific strengths and weaknesses and learned to provide continuing education sessions. For the IBI chapter members: each increased her knowledge and skills in the family planning through participation in continuing education sessions; increased her participation in IBI, particularly those bidans in the more rural chapters, and increased her communication with other providers of maternal-child health care. For the IBI chapter boards of directors: in the PR project, the assumed responsibility for the quality of care provided by midwives and as a result gained increased respect professionally for IBI; increased reporting from its members. For IBI Province: as a result of the PR Project, the province developed a standard recording form and clinic register for all BPS in Central Java and successfully managed both PR and FR programs. For clients of BPS involved in PR: the BPS demonstrated better record keeping so clients receive better follow-up visits and/or referrals and increased sensitivity to a client's need for privacy during counseling and examinations. For other health care providers: the PR Project demonstrated the utility of face-to-face, on-site evaluation of health care providers in Indonesia. For fundraising committees: each member developed negotiation and financial management skills.

Recommendations

1. Local IBI chapters should be given encouragement, appropriate technical support, and explicit responsibility for quality assurance, with but one approach being PR. Quality assurance activities should include midwives and practice sites other than BPS, such as bidan di desa working in the villages, midwives working in the government health centers, and midwives working in birthing centers and hospitals. In order not to run out of topics addressed by this process PR should include the full scope of midwifery care, not just FP. It should include management issues like recording and equipment maintenance; clinical topics should deal with risk-screening based on types of cases referred as well as care provided by the midwife.;

2. A stronger and more complete set of midwifery practice standards/clinical guidelines should be developed before continuing or expanding peer review. These guidelines should be revised as needed in order to be in agreement with international standards. The advice of available experts should be sought as needed for the drafting of any additional SOPs and related checklist. The SOPs should include, or be developed specifically for the management of side-effects and complications.;

3. Checklists based on these midwifery SOPs/clinical guidelines used for PR should emphasize the process/performance of procedures for all routine services as well as for the management of side effects and complications. Peer review is based on the assumption that individual professionals vary in the strength and weakness of their knowledge and skills, that professionals can learn from one and other and want to practice at the highest level possible for them and that the PR process is a non-punitive one with the reviewer being a member of the same profession working in similar but not the same clinical setting without any supervisory responsibility for the peer being reviewed. Focusing the checklists on procedures allows the reviewer to assess the midwife's performance, and help her learn how to improve it. Whether the creation of SOPs and checklists should be part of the PR training and process in the future is not known. Both approaches should be tested and the results compared.;

4. Continuing education should be based on the learning needs of midwives and problems identified in their practices. Continuing education should continue whether or not PR is

continued. Sessions should include presentations by IBI members with supplementation by outside experts as needed e.g. midwifery instructors and obstetrician-gynecologists. The expertise of chapter training teams should also utilized in the preparation and presentation of the sessions.;

5. Fundraising committees should be organized and provided with start-up capital to raise money for chapter-level quality assurance and continuing education programs.;

6. During any continuation or replication of this project, all committees should include a mixture of both board members and younger midwives. Old members should overlap with and orient new members. The tenure of committee members should be from one to three years depending on the local situation.;

7. Continued monitoring of this project should be carried out through summer or fall 1994 in order to determine the long-term sustainability of this model of peer review.;

8. Special IBI project should focus on maternal health as well as family planning.;

9. IBI chapters should institutionalize outreach to bidan di desa, the youngest, least well trained, least experienced and most isolated members of their profession. ; and

10. If peer review is continued, it is recommended that monitoring forms be limited to a single quarterly report form each PR committee with: a summary of the findings from the site visits, feedback from the midwives reviewed, and feedback from the participants at the continuing education session(s) and a single quarterly reports from each FR committee with monthly balance sheets. Checklist can be used for peer review and also, if desired, for self assessment by midwives or by midwife "supervisors" for evaluation of their staff.

34. IBI Peer Review: Final Report (8/95)

MacDonald, Patricia, et al. *"The Peer Review Program of the Indonesian Midwives Association: Final Report of Phase Two of the Pilot Project."* University Research Corporation, Jakarta, August 1995.

Topic of study: **IBI, Midwives, Peer Review**	Language of original report: **English**
Type study: **OR**	Location of report: **IBI**
Duration of study: **September 1993-March 1995**	File name of report: **Peer_IBI**
Location of study: **West Java, East Java, Bali (4 regencies each)**	Date of report: **August 1995**
Study Director: **Patricia MacDonald**	Funding: **PSFP**
Technical assistance: **ACNM, URC, PSG**	Summary prepared by: **Jack Reynolds**

This paper describes the implementation and results of the second phase of the pilot test of the Peer Review Program of the Indonesian Midwives Association (IBI, Ikatan Bidan Indonesia). It also includes an assessment of two substudies: one on the validity of the peer reviewers' observations; and the second on a test of self-assessment as an alternative to on-site visits by peer reviewers. Finally, the paper examines the impact of the program on the quality of care provided by the midwives.

The Peer Review program is one of the success stories of the Private Sector Family Planning project, and we hope that this report will not only demonstrate why, but serve to provide additional support to IBI so that peer review can be established in all IBI chapters throughout Indonesia.

The Peer Review Program

In April 1992, the Indonesian Midwives Association (IBI) began a program of Peer Review. In this program, midwives review the care provided by other midwives, provide feedback to those midwives reviewed about their strengths and weaknesses, and use the findings from several reviews to tailor continuing education sessions for many midwives based on common weaknesses observed in midwifery practices. The review consists of observing care delivered to clients, interviewing clients, reviewing the client's medical record, and interviewing the midwife about her performance. Checklists are used by the reviewer to conduct the assessment; the content of the checklists is based upon professionally accepted clinical guidelines.

A total of 12 regencies in four provinces participated in the pilot test - four regencies in Central Java participated in the first phase, and four regencies in West Java, East Java, and Bali participated in the second phase.

The peer review activities are implemented in "cycles", each cycle corresponding to the review of a specific topic. The average amount of time required to complete one cycle is three months.

A total of 380 midwives received visits during the three cycles of peer review, and over 1,300 client-provider interactions were observed. This represents 13% of all midwives or 30% of all private-practice midwives who benefited from receiving peer review visits.

Overall, the members of the peer review team reported that they had very few difficulties implementing the 'technical' aspects of the program, such as using checklists and tabulating

findings. The difficulties identified by the team members include shortages of time for all team members to meet together to plan, implement and finalize activities. They cited changes in the government work hours, now a five-day work week, as the primary hindering factor.

The feedback from the midwives indicated that the "most difficult" part of the peer review visit was the feedback. However, they overwhelmingly reported that the feedback was also the "most useful" part of the entire visit. When asked how their clients felt about the visit, the midwives responded that the peer review visit was also a positive experience for their clients; none of them received any negative feedback from their clients. Finally, the midwives felt that the length of the visit was "just about right", not too long, and not too short.

The overwhelming response of the teams is that they are satisfied with their work and the outcomes of the peer review program. This reflects the feedback received from the midwives reviewed, the improvements in quality observed, and the knowledge and skills the reviewers gained from the experience. These same sentiments were echoed by members of the fundraising teams as well as by the provincial management teams..

Self-Assessment as an Alternative to Site Visits

Reviewers in the urban and periurban regencies experienced greater difficulty finding the time to conduct peer review visits. They suggested trying to find an alternative mechanism for identifying weaknesses with midwifery practices, so that they could continue to focus their continuing education sessions on specific and common weaknesses for that topic. As a result, a Self Assessment tool was pilot tested in 3 provinces as an alternative means of assessing the quality of midwifery practice.

Each of the 12 IBI chapters participating in phase 2 of the peer review program, also participated in testing the self assessment form. The study lasted for nine months and consisted of three cycles of peer review. Each cycle focused on a different family planning topic - injectable contraceptives, IUDs, and oral contraceptives. A total of 250 self-assessment forms were completed for injectable contraceptives, 252 for IUDs and 163 for oral contraceptives. (Not all of the 12 IBI chapters reviewed oral contraceptives during the third cycle.)

The results showed that

- self-reported performance of family planning activities by midwives was nearly identical to the results obtained through direct observation of the performance during peer review visits.

- With each consecutive peer review/self-assessment cycle, the differences in the scores of the two types of assessments narrowed.

- Midwives did not overreport their performance on the self assessment forms.

Clearly the implications of this study are that self assessment can be used as an alternative to direct observation during peer review visits as a means to identify strengths and weaknesses in midwife performance. However, IBI feels strongly that peer review and direct observation are the preferred method of assessment whenever possible. In lieu of

direct observation, a self assessment tool, which is derived from clinical standards and based on the peer review checklists, can be used to assist in identifying areas of performance needing improvement.

Midwives as Peer Reviewers

The primary objective of this substudy was to determine the accuracy of midwives, trained as peer reviewers, to use checklists to assess the performance of other midwives. In each of the three provinces a research assistant was hired to accompany the peer reviewer and make her own observations. Each research assistant was a trained midwife who is clinically active, and regarded by her colleagues as someone who provides high quality services. For purposes of this study, she acted as the "gold standard" against which the peer reviewer's capability to use checklists and assess service quality was compared.

Each research assistant accompanied 10 peer reviewers, all randomly selected, for each cycle/topic. Thus, 30 accompanied visits were made for each cycle, for a total of 90 peer reviewer-research assistant visits in the three study provinces.

During the jointly-conducted peer review visits, the peer reviewer and the research assistant each had a set of checklists, which they filled in independently. No discussion was allowed between them. Up to five provider-client interactions were observed during a single visit, these five clients were then interviewed and their medical records reviewed, and finally the midwife who provided the service was interviewed.

The results showed that the peer reviewer and research assistant made the same observations more than 80% of the time. Where there were discrepancies, they seem to be due more to the phrasing of the peer review item than the observations.

In summary, the results of this study indicate that trained peer reviewers are able to use checklists and to accurately assess the quality of family planning services provided by midwives.

Peer Review and Quality of Care

The objective of this study was to determine whether there was any measurable improvement in performance of family planning services delivered by midwives between the initial peer review visit and a follow-up visit three months later.

This study compares the frequency of tasks performed well during the initial visits with those performed well during the follow-up visit. The observation checklist was the basis of the assessment. It contains a number of activities or tasks that the midwife should perform while providing family planning services to her clients.

Three months after each cycle of peer review, half of the midwives visited for a topic (five per chapter) received a follow-up visit from the peer reviewer in the subsequent cycle. Those to be revisited were randomly selected from the list of midwives initially visited for that topic.

The results show that IBI's peer review program is effective in improving the quality of family planning care delivered by midwives. The level of improvement between initial and follow-up visits increased with each successive cycle of peer review. The level of

performance observed during the initial visits also increased for many categories of activities with each successive cycle of peer review.

Improvements in the level of performance between the initial and follow-up visits was due primarily to the feedback given to the individual midwife immediately after the peer review assessment. This feedback provided her with specific information about her strengths and weaknesses, and enabled her to discuss ways of improving her clinical practice. When that clinical service was reviewed three months later, improvements were noticed across the board for all activities within that service.

It is also likely that the peer reviewers' ability to give feedback improved with the experience gained in each peer review visit, as did their ability to conduct an accurate assessment of performance. This would help account for the greater levels of improvement seen with each successive cycle of peer review.

Increased levels performance observed during the initial visits of the three topics is a likely result of the peer review program's continuing education component. The continuing education seemed to have a generalized positive effect on midwife performance, particularly for skills such as taking a history, conducting an examination, and providing counseling and education. Overall levels of performance for these categories of activities showed a steady increase from one cycle of peer review to the next, even though the midwives and the topics reviewed for each cycle were different. This steady increase in the quality of care might also be attributable to the increased emphasis placed on improving performance by IBI during the chapter's professional meetings.

Conclusion

IBI's peer review program has proven to be successful on many levels -- the direct benefits range from improving the quality of care for specific contraceptive services, to improving the quality of care across different contraceptive services, and improving the ability and performance of the peer reviewers to conduct assessments, provide feedback and deliver continuing education sessions. The secondary benefits are that it has increased attendance at IBI's professional meetings, improved the professional image of the midwifery association, helped strengthen the leadership and technical capabilities within the association, and promoted the status of the entire midwifery profession. IBI should be encouraged and supported in its efforts to expand the peer review program to all its chapters throughout the country.

LONG-TERM METHODS

35. SRI Survey Findings on VS (9/92)

Survey Research Indonesia. *"Research on Voluntary Sterilization in Jakarta and Surabaya: Key Findings and Marketing Implications."* Jakarta, September 1992.

Topic of study: **VS**	Language of original report: **English**
Type study: **Diagnostic Survey**	Location of report: **TFG, SRI**
Duration of study: **June-September 1992**	File name of report: **C-2027/26.9.92/SL12**
Location of study: **Jakarta and Surabaya**	Date of report: **September 9, 1992**
Study Director: **NA**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Jack Reynolds**

This report summarizes the key findings from interviews with 511 respondents selected at random from B and C households, all of whom want no more children; and four focus groups, again composed of respondents who want no more children.

Key Findings

Awareness of VS is low. Tubectomy is more popular than vasectomy. Hospitals are the major source of sterilization. Tubectomy is chosen because: no side effects, best if don't want any more children, provides freedom of fear from pregnancy, is a long-term method. Hospitals are valued as being convenient, economical, well-equipped. The husband/wife is the main person providing advice to the acceptor. Doctors are also important. Satisfaction is very high (100%). Reasons are the efficient and friendly service.

The main fear among non-acceptors is the operation itself, followed by fear of side-effects. Hospitals are the best source for providing information on VS. TV is the best channel for mass-media information about VS, followed by radio, posters, leaflets. Some respondents want information on VS through informal/formal discussions. The best participants for these discussion are doctors and VS acceptors. The best time to provide information is after the birth of the 2nd or 3rd child, followed by when the wife reaches age 35.

The most positive attitudes about VS are: never have children again, most effective method, can go home the same day, many important people have had it. Only a minority say it is expensive, against religious beliefs, decreases the sex drive or is difficult to get. The most negative attitudes are: similar to castration, causes weight gain, fear of operation, can't do heavy work. VS users are the best sales team.

Marketing Mix

Product: VS is a good product. Users like it. Non-users fear it. There is a lot of misinformation around. "Kontap" as a brand needs promotion (only 11% know the word).

Place: Near home best. Local hospital/clinic best place to offer VS.

Promotion: Through media to educate/inform and address some of negative misperceptions. Through counseling to present details. Involvement of acceptors (testimonials) seems key.

Price: Segment the market. Make it cheap for the less well-off, more expensive for the better off.

36. VS Acceptance in Indonesia (12/92)

Reynolds, Jack and Russ Vogel. *"Why Acceptance of Voluntary Surgical Contraception is Low in Indonesia. A Background Paper prepared for the National MKET Review Meeting, December 14 - 17, 1992."* Project Support Group, Private Sector Family Planning Project, BKKBN. Jakarta, December 1992.

Topic of study: **VS**	Language of original report: **English & Indonesian**
Type study: **Analysis**	Location of report: **PCS, URC**
Duration of study: **September-December 1992**	File name of report: **VSC_1130**
Location of study: **National**	Date of report: **NA**
Study Director: **Jack Reynolds**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Jack Reynolds**

Background

This paper compiles findings from a number of studies, surveys and analyses in an attempt to determine why acceptance of voluntary sterilization is so low. It gives special attention to the questions of supply vs. demand, the reasons couples do not accept VS, and the role of mass media and interpersonal communication. The major findings, conclusions and recommendations are summarized below.

The Problem

Acceptance of Voluntary Sterilization (VS) is relatively low in Indonesia. This does not appear to be due to lack of supply. There are adequate facilities, they are accessible, service quality is very good, and prices are not an obstacle.

The problem is a lack of demand. Although there is a significant pool of couples who should consider VS, very few do. This appears to have less to do with awareness of VS than with gaps in factual knowledge about the method (especially about the operation and potential side effects) and motivation to use it. Many potential acceptors are afraid of the operation and its potential side effects. They lack accurate information about the operation, possible side effects, and also about the advantages of VS.

Intervention Strategies

1. Acceptance could probably be increased significantly if BKKBN could conduct a massive campaign to increase knowledge, dispel myths, and in other ways promote acceptance of VS. Unfortunately, this is not feasible at the moment.

2. Given this situation, and what we already know about the characteristics of potential acceptors of VS, the information they need, and what motivates them, a "direct marketing" approach to the promotion of VS may be the best alternative..

Although there may be younger women with 2 children interested in VS, the prime target groups are likely to be older women (30 and above) in urban areas, who are better educated, and who have 3 or more children.

The pool of potential acceptors in any given area is likely to be quite low. Roughly, it would be about 2-5% of all eligible couples. Among those who meet the *bahagia* criteria (marital harmony, parity, age), perhaps 5-10% could decide to adopt VS. This implies the need for a very selective identification and motivation approach rather than a mass media campaign.

The key messages that positively motivate couples to accept VS are: it is the best method if you don't want to have any more children; it eliminates the fear of pregnancy; it is the safest method for your health (the least amount of side-effects); and it doesn't interfere with sex (no bother).

An important message to convey to potential acceptors is the increase in sexual pleasure that may result from adopting VS.

The best strategy for motivating people to accept VS is to use satisfied acceptors to speak to both the husband and wife.

The best way to enable interested couples to have their questions answered is through face-to-face contact with people who have already had the operation. Therefore, the centerpiece of the strategy must be face-to-face contact between interested couples and satisfied users.

Linking Communities to VS Service Points

In addition to improving the messages and adopting a direct marketing approach, it will also be important to strengthen the ISRF (Information, Screening, Referral, Follow-up) system in each hospital's catchment area, including field worker knowledge of VS and where it is available.

Conclusions

The reason that VS acceptance is low in Indonesia is not because of the lack of supply. There are adequate facilities, they are accessible, service quality is very good, and prices are not an obstacle.

The problem is a lack of demand. Although there is a significant unmet need, some 50% of couples do not want to have any more children and should consider VS, very few do. This appears to have less to do with awareness of VS than with gaps in factual knowledge about the method (especially about the operation and potential side effects) and motivation to use it.

Recommendations

If VS acceptance is to increase significantly in Indonesia, then the following would need to be done:

- Improve the capability of front line personnel (private midwives, FP/health providers in the community, PLKB, PPKBD, non-VS hospital staff) to identify potential VS clients, provide correct information about VS, correctly screen both male and female clients, make referrals, and follow-up on post-surgical clients for appropriate action.

- Strengthen the linkage between VS units and the surrounding community, FP/health providers in the community, and non-VS departments in the hospitals.
- Improve the knowledge and reduce fears of potential acceptors about VS, the operation, its advantages, risks, and the location and cost of services.
- Develop an effective way to utilize satisfied acceptors as motivators
- Develop the capability of hospital staff to use social marketing techniques to promote acceptance of VS

37. LTM Data: 1994 (5/94)

Reynolds, Jack. *"LTM Data through March 1994."* Project Support Group, Private Sector Family Planning Project, BKKBN. Jakarta, May 18, 1994.

Topic of study: **LTM, VS**	Language of original report: **English**
Type study: **Analysis**	Location of report: **USAID**
Duration of study: **May 1994**	File name of report: **SAID0518, KONTAP.WQ1**
Location of study: **National**	Date of report: **May 18, 1994**
Study Director: **Jack Reynolds**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Jack Reynolds**

Background

This report presents a large number of tables on new acceptors drawn from BKKBN service statistics from April 1990 through March 1994 for IUD and Norplant, and from April 1989 through March 1994 for Voluntary Sterilization. Data are by province and "region" (Java-Bali, Outer Islands I, Outer Islands II). Tables are arranged in rank order with provincial and cumulative percentages.

Findings

Examples of the type of findings that can be drawn from these tables are:

IUDs: Jatim has had the most acceptors over the last four years (727,262, or 24% of the total). TimTim has had the least (1,779, or 06% of the total). Three provinces accounted for over half (51.3%) of all IUD acceptors; 15 provinces accounted for less than 10% of all IUD acceptors.

Implants: Jatim, Jateng and Jabar have each been the number one province in terms of implant acceptors over the past four years, averaging around 60,000 each per year.. Together they have accounted for 58% of all implant acceptors. Bali has accounted for the least amount (1,640 over four years).

Sterilization: Jabar, Jateng and Jatim have also been the major players where VS acceptors are concerned, averaging between 20-32,000 new acceptors each per year. TimTim has produced the least, 556 acceptors in five years. Nine provinces account for over 90 percent of all VS acceptors.

Other Results

Voluntary Sterilization: The decline is steady and significant. The number of acceptors has dropped 19% since 1990/91. The project goal for this year was 290,000 new acceptors. The figures show that the project came nowhere near that (118,224 acceptors), even after BKKBN reduced the target in mid-year to 145,000.

IUDs: The decline in IUD acceptors has also dropped steadily since 1990/91 (27%). This is particularly disturbing, since the IUD is arguably the best all-around method (easy to provide, fewest side-effects, lasts for 8 years now, inexpensive, widely available). The drop in Jatim has been especially significant (from 212,464 in 1990/91 to 147,273 in 1993/94 -

some 65,000 acceptors/year). Sumut is also way down (45,000), as is Jateng (61,000). Jabar is up, on the other hand (21,000).

Norplant: New acceptors dropped in 1991, but then rose again. Total acceptors this year exceeded those in 1990/91 by 9,000). Although that's a bright sign, this is a very expensive method, fraught with all sorts of insertion and extraction problems, and it is real drain on the GOI budget. It is worth asking if it should be promoted at all.

The charts (and tables) provide much more data on trends overall and by province. An important item to examine is the proportion of acceptors that come from each province. In general, the impact of LTM acceptance is accounted for by 10 of the 27 provinces. The (so-far) unanswered question is whether it is worthwhile (cost-effective) to invest large amounts of funds to make all methods equally available and accessible throughout the country.

38. New Acceptor Statistics: 1994/95 (6/95)

Reynolds, Jack. *"New Acceptor Statistics for 1994-1995."* Project Support Group, Private Sector Family Planning Project, BKKBN. Jakarta, 15 June 1995.

Topic of study: **LTM, VS**	Language of original report: **English**
Type study: **Analysis**	Location of report: **USAID**
Duration of study: **June 1995**	File name of report: **PSG_0615; New-Aks.wq1**
Location of study: **National**	Date of report: **NA**
Study Director: **Jack Reynolds**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Jack Reynolds**

Background

This report supplements a similar report prepared the previous year.[8] It presents a large number of tables on new acceptors drawn from BKKBN service statistics from April 1994 through March 1995 for IUD and Norplant, and Voluntary Sterilization Unlike the previous report, there are no breakdowns by region and province.

Findings

The total number of acceptors rose this year, and long-term method acceptors accounted for 28 percent of that increase.

IUD acceptance declined by three percent, but it remains the most popular long-term method at 642,490 acceptors this year compared to 485,108 for implants and 103,026 for VS.

Implant acceptance rose by 143,353 acceptors over the previous year, or 42 percent.

VS acceptance has dropped for the fifth year in a row. It is 8 percent lower than last year and 33 percent lower than the peak year of 1989/1990.

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[8] Reynolds, Jack. *"LTM Data through March 1994."* Project Support Group, Private Sector Family Planning Project, BKKBN. Jakarta, May 18, 1994.

39. PKMI Sustainability Analysis (6/94)

Reynolds, Jack, and the PKMI Sustainability Analysis Committee. *"An Analysis of the Sustainability of PKMI. A Report Prepared for the U.S. Agency for International Development (USAID), The National Family Planning Coordinating Board (BKKBN), and The Indonesian Association of Voluntary Sterilization (PKMI)."* University Research Corporation, Jakarta, 28 June 1994.

Topic of study: **VS, PKMI, Sustainability, Costs**	Language of original report: **English**
Type study: **Analysis**	Location of report: **PKMI, USAID**
Duration of study: **January-June 1994**	File name of report: **PKMI_SA8**
Location of study: **National**	Date of report: **June 28, 1994**
Study Director: **Jack Reynolds**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Author**

In January, 1994, USAID/Jakarta organized a meeting of all USAID "Cooperating Agencies" (CAs) that have family planning/population activities in Indonesia. One of the recommendations that came out of that meeting was to conduct a "Sustainability Analysis" of PKMI. BKKBN participated in the concluding session of that meeting and endorsed the recommendation.

The Committee was formed and held its first meeting on February 11, 1994, and roughly every month thereafter. Sustainability was defined here as the ability of an organization to raise sufficient funds to continue to carry out its functions and activities. All three users of the analysis (BKKBN, USAID and PKMI) have the same basic purpose in mind for the analysis: to develop a strategy for sustaining PKMI's functions and activities for the next 10 years (1995-2004). It is assumed that this will contribute to an outcome that all users hope to see, which is high quality VS services and a significant number of VS procedures.

A distinction has been made between "core" activities and "special projects." "Core Functions" are those that are expected to be carried out routinely each year. "Special Projects" are short-term activities (1 month, 1 year, 2 years) that are contracted with PKMI by BKKBN, USAID, or others. These can include training, pilot projects, development of VS materials, etc. Practically everything PKMI does at present is funded as a short-term, special project.

Over the next few years, VS training of trainers will probably be turned over to the National Resource Center. VS services will continue to be provided by hospitals and clinics that have been certified by PKMI. BKKBN will continue to provide subsidies to these units to pay for services. Mass media promotion of VS will probably remain politically unacceptable, and other forms of demand creation will also be restricted. Thus, PKMI will not be responsible for any of the above.

Therefore, the committee examined the feasibility of PKMI raising sufficient funds to be able to carry out four core functions and selected special projects over the next 5-10 years (1995-2004):

- update VS standards annually (training, service delivery, equipment, materials), and assist in VS policy development

- ensure compliance with those standards (training, service delivery, equipment, materials) at the national and provincial levels,
- assist BKKBN, Depkes and others in planning, evaluating and coordinating VS activities
- carry out a limited number of equipment maintenance and direct VS services in PKMI clinics
- carry out special projects under contract (training, supervision, evaluation, materials development, demonstration projects, etc.)

A detailed set of budgets was prepared by PKMI for each of the core functions described above. Special projects that PKMI undertakes will be fully-funded. That is, they will not require PKMI to draw on other sources of funding to support them, even partially.

Nine iterations of these budgets were prepared as some activities were eliminated, others were combined with one another, and most were reduced in scope (and, therefore, in budget). Estimates were made for revenues as well as expenditures starting in 1995, and the balance (surplus or deficit) was computed for each year through 1999, the first year without SDES funding. Estimates were not prepared for the second five-year period, since they would be similar to the 1999 estimates.

Adjustments were made for: changes in the exchange, inflation; improved productivity/efficiency of operation; and additional revenue generation.

Currently, PKMI is completely dependent on USAID support to carry out these activities and will probably be able to continue operating at current levels through 1998, largely with SDES[9] funds. PKMI expects to spend around $1 million per year. An assessment of alternative (non-USAID) income-generation activities shows that none are likely to raise enough funds to support any of the above core activities. PKMI will be able to raise about $30,000 per year. That is, PKMI is not self-sustainable.

Private donations and contributions from other donors (UNFPA, ADB) are also unlikely to produce any significant, sustained revenue, at least over the next 10 years. Assuming that USAID support will end in 1998, the only medium-term source of support for continuing PKMI's core activities is the Government of Indonesia (GOI), especially BKKBN, and possibly the Department of Health (Depkes).

BKKBN will need to start phasing in support of PKMI over the next 3 years to ensure that these core activities are continued after SDES funds end in 1998.

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[9] Service Delivery Expansion Support, a five-year, USAID-funded project managed by Pathfinder International.

40. Contraceptive Method Mix (11/94)

Galway, Katrina and Jack Reynolds. *"Contraceptive Method Mix in Indonesia. An Analysis of the Fertility, Health and Programmatic Implications of Greater Promotion of Voluntary Sterilization. A Report Prepared for BKKBN and USAID."* Jakarta, Indonesia. November 7, 1994

Topic of study: **VS, LTM, Costs**	Language of original report: **English**
Type study: **Analysis**	Location of report: **TFG, URC, USAID, PCS**
Duration of study: **May-November 1994**	File name of report: **VSMMIXR4**
Location of study: **National**	Date of report: **November 10, 1994**
Study Director: **Katrina Galway**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Authors**

Overview

This study is one of several designed to contribute to an overall analysis of the prospects for Voluntary Sterilization (VS) in Indonesia. The prevalence of VS is relatively low in Indonesia, and acceptance rates have been declining over the past few years. The purpose of this study is to develop a series of fertility and cost projections based on a variety of contraceptive method mix scenarios, in particular, scenarios with high and low VS prevalence.

Twelve different scenarios were developed, the most relevant of which are four that are based on younger vs. older age acceptance of VS and the current method mix vs. a mix that reflects unmet demand. The most important of these scenarios is the "Old-Best" mix, which is based on two important conclusions from the 1991 IDHS. The first is that most women want to have their children in their early to mid-20s and then limit pregnancies for the rest of their reproductive lives. The second is that a very large number of women fall into a category where VS is clearly the most appropriate method for them. Thus, the "optimal" strategy for achieving the program's fertility goal of a TFR of 2.1 by 2005 is: 1) concentrate on women who have already fulfilled their fertility objectives (2 children); and 2) provide as many as possible with the method that they think is best for them - voluntary sterilization.

The analysis also shows that this would be the least expensive approach. In general, long-term methods are 300-400 times less expensive than pills and injectables.

Fertility and Method Mix

Theoretically, any method mix can be successful. The Greeks did it with abstinence, the Japanese with condoms. But practically, achieving replacement fertility will be an uphill battle for Indonesia without a significant increase in VS. There are six compelling reasons for increasing acceptance of VS:

1. **Demand Fulfillment Requires It.** A large number of couples would quickly accept VS if they knew about it and understood the advantages and disadvantages.

2. **Experience from Other Countries Supports It.** VS is the most commonly used method around the world, averaging 36% overall and 44% of method mix in

developing countries. Regression analyses show that practically all countries in Asia that have reached a total prevalence of 60% or above (Japan is the exception) have had high levels of VS (from 23% to 48%).

3. **Successful Provinces in Indonesia Have High VS Use.** The five provinces with the greatest success in reducing fertility have a prevalence of VS that is three times greater than that of the other 22 provinces.

4. **Adding More Methods Improves Choice - and Increases Prevalence.** Studies have shown that when a new contraceptive method is added, contraceptive prevalence increases about 12%. This is probably because as a wider range of methods becomes available more couples are likely to find a method they will accept. Adding (or increasing) VS also affects prevalence directly. Each acceptor of VS equals a lifetime increase in contraceptive prevalence, and a lifetime decrease in the TFR. No other method can guarantee that because of failure rates and dropouts.

5. **Maternal Mortality Can Be Reduced.** The risk of maternal mortality increases as age and parity increase. If VS were used by all women over age 30 and all women with three or more children, maternal mortality would be reduced by at least half in Indonesia.

6. **Costs are Lower.** VS costs are high at the beginning because of the investment required. But this declines rapidly as more operations are performed and as the cost of providing family planning services for 10-15 years is eliminated for these women.

Method Mix Scenarios for Indonesia

This analysis shows that the "demand" for VS is already high and could be much higher if VS were better known (knowledge of this method is the lowest of all methods) and if couples understood its advantages and risks (many people are unnecessarily afraid of the operation and its side-effects). The analysis projects four method mix scenarios (mentioned above) and demonstrates that even with the strictest requirements, the pool of potential acceptors is huge.

Of the four scenarios, the "Old-Best" method mix scenario is the best. It is based on the following eligibility criteria - which are much more strict than those currently used:

- Want no more children
- Wife is at least 25 years of age
- The couple has at least 2 living children
- If the couple has only two living children, the youngest is at least two years old
- The wife and husband have discussed their ideal number of children
- The wife says that the husband wants the same or fewer children than she does
- The wife is knowledgeable about contraceptive methods (she knows at least one short-term method (pills and/or injections), one long-term method (IUDs and/or implants), and one permanent method (tubectomy and/or vasectomy); and

Eleven percent of ELCOs meet **all** of these criteria. In 2005 there will be approximately 5.65 million women who meet these criteria. Most of them (4.3 million, or 75 percent) will

be in 8 provinces, and 53% in just three provinces: Jatim, Jateng, and Jabar. Thus, the unmet need is clearly there. This figure would reach 19 million if the information and communication obstacles noted above were met.

Method Mix and Maternal Mortality

This same number of women are prime candidates for VS for another reason - to reduce maternal mortality. As noted above, the women most at risk of dying from pregnancy-related causes are older women and women of higher parity. Thus, the strategy for reducing maternal mortality should be based on two principles: 1) avoid all unwanted pregnancies; and 2) increase contraceptive use by older and high-parity women. Theoretically, this can be done with any contraceptive, but almost all of these women are prime candidates for VS, and it is the one method that will ensure that they do not become pregnant. And if they do not become pregnant, they are free from the risk of maternal mortality.

Costs and Programmatic Implications

The service costs of each contraceptive method were computed from special studies, BKKBN and 1991 IDHS data. They were then put into a computer program called *Target-Cost*, to compute the costs of 12 different method mixes, including the four mentioned above. Costs clearly vary by method, with pills and injectables the highest and long-term methods much lower. For example, the net cost* of a program that consisted only of tubectomy would be about Rp 1 billion/year in 2005. The net cost of an injection program would be Rp 349 billion, and a pill program would cost Rp 446 billion.

Costs are affected by six major factors:

1. The number of new acceptors needed each year (VS requires fewer)
2. The number of visits required each year (VS requires fewer)
3. The more contraceptives needed each year (VS requires none)
4. The number of complications and side-effects (vasectomy is high now, but could be reduced easily)
5. The age of the acceptor (average age of wife is 31 years for tubectomy and 28 for vasectomy)
6. The amount of cost recovered through patient charges (much better with VS)

In general, VS comes out ahead on all of these criteria. But a single-method program is not feasible. Nevertheless, costs can be reduced by increasing acceptors of long-term methods, especially VS. The "Old-Best" scenario described above is the least expensive scenario of the four presented. By 2005 it would cost Rp 141 billion/year or about Rp 5,102 per user. And it would require 5.5 new acceptors each year. In contrast, the current method mix would cost Rp. 217 billion/year, which is Rp 7,833 per user, and it would require 6.9 million new acceptors each year.

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* Net cost is the total "gross" cost less client payments for services.

Conclusions

It is clear from the analysis that VS is a "preferred" method for many Indonesian couples and that the program would have a much better chance of meeting its fertility goals, would make a great contribution to maternal mortality reduction, and would do this at less cost if VS acceptance were increased. But to do this will require a significant increase in VS acceptors. The current target is only 129,300 new acceptors this year, but the "Old-Best" scenario would require 543,330. This is a large number, but, as noted above, there are many potential acceptors in Indonesia - almost 10 times this number.

To achieve such a significant increase, four strategies are suggested:

1. **Increase awareness of VS** - the 1991 IDHS showed only 30% aware of vasectomy and 55% aware of tubectomy. This is one of the two major barriers to VS acceptance.

2. **Overcome fears of VS** - many potential acceptors are unbelievably misinformed about the VS operation and its consequences. This is the most important barrier to acceptance among those who know that VS is an available method.

3. **Improve the quality of VS services** - complications and side-effects are very high, and can be practically eliminated by improving quality of care. The costs would then be reduced by 20-50% as well.

4. **Find ways to reduce costs** - there are too many service sites, the majority of which are unused. To date the program has put almost all of its resources into improving the supply side of VS and very little in the demand side. The majority of operations are conducted in 25% of all of the nations hospitals. The others average about 2 operations per month.

5. **Increase economies of scale** - it would be much better economically and in terms of quality to perform more operations in fewer facilities. This would not only reduce costs but improve quality. Right now, most of the facilities do not have enough operations to maintain the skills of the staff.

6. **Increase acceptance of vasectomy** - this method has the best potential of all to be the most effective and least expensive. But to do so the quality of service must be improved (complication costs are the highest of all methods).

41. Contraceptive Method Mix Estimates: Repelita (9/94)

Reynolds, Jack. *"Kontap Method Mix Estimates for the 'Repelita' Scenario."* Memorandum to Dr. Ratna Tjaya, Bureau of Planning, BKKBN. Jakarta, 27 September 1994.

Topic of study: **VS, LTM, Costs**	Language of original report: **English**
Type study: **Analysis**	Location of report: **BIREN, URC**
Duration of study: **September 1994**	File name of report: **NA**
Location of study: **National**	Date of report: **NA**
Study Director: **Jack Reynolds**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Jack Reynolds**

Background

After the presentation of the preliminary findings from the "Method Mix" analysis,[10] Dr. Ratna asked PSG to run a scenario that reflects the method mixes found in Repelita V-VII. Tables were prepared to show the results of that scenario from 1991-2005, and to make comparisons with three other scenarios that were presented in the Method Mix paper: 1) the "current" method mix, taken from BKKBN reports for 1993-1994; 2) the "Young-Best" scenario that emphasizes increased use of VS among younger women); and 3) the "Old-Best" scenario that emphasizes increased use of VS among older women. This is also called the "optimum" scenario in the Method Mix study.

Method Mix Patterns Used

In general, the Repelita mix does not change much from year to year. Kontap actually goes down at first and then goes up by a very small amount, reaching a high of 6.4% in 2005 (lower than in 1991 when it was 6.7%). IUDs are steady, dropping only 2.4 percentage points over the 15 years. Norplant goes up from 6.3% in 1991 to 9.0% in 2005. The injection makes the largest gain, going up 7.5 percentage points (23.6% to 31.1%). Pills decline from 29.8% to 27.7%. Overall, there is a small increase in long-term methods, from 36.7% in 1993 to 39.8% in 2005.

Outputs of the Repelita Method Mix

In 2005 the program would have to have almost 28 million active users, over 6.5 million new acceptors, and would cost Rp 235 billion per year for services. The total cost from 1993-2005 (13 years) would be Rp 2.5 trillion. Cost recovery would be very low (1/10 of 1 percent of gross costs), and the annual cost per user would be Rp 8,457.

Acceptors and Users Required

All of these scenarios will achieve the fertility goal of 2.1 TFR by 2005. And there is not much difference among them in terms of the number of users who have to remain active. What is most different is the number of new acceptors required. For example, in 1993,

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[10] See Galway, Katrina and Jack Reynolds. "Contraceptive Method Mix in Indonesia. An Analysis of the Fertility, Health and Programmatic Implications of Greater Promotion of Voluntary Sterilization. A Report Prepared for BKKBN and USAID." University Research Corporation, Jakarta. November 9, 1994.

only 100,600 VS acceptors are required (64.6 tubectomy + 36.0 vasectomy). By 2005 that will be 242,080. By contrast, 1.4 million new IUD acceptors will be needed, 1.8 injection acceptors, and 2.6 million pill acceptors.

Comparisons with Other Method Mix Scenarios

There is not much difference in the number of active users required by the four scenarios, but the Repelita scenario will require the most. However, it would require fewer new acceptors than the current mix, but about one million more per year than the "Old-Best" scenario. This is a big difference and one of the main factors that affects costs. The costs of the Repelita scenario are the highest of the four, and almost 50% higher than those of the "Old-Best" scenario.

42. Assessment of VS in Indonesia (10/94)

Ross, John and Firman Lubis. *"Assessment of Voluntary Sterilization Activities."* AVSC International. Jakarta, September/October 1994.

Topic of study: **VS**	Language of original report: **English**
Type study: **Analysis**	Location of report: **USAID, AVSC, URC**
Duration of study: **September-October 1994**	File name of report: **NA**
Location of study: **National**	Date of report: **October 1994**
Study Director: **John Ross**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Authors**

This review, prepared for BKKBN and USAID and funded by AVSC, makes 12 recommendations to advance voluntary sterilization (VS) in Indonesia.

Findings and Conclusions

We conclude that increased use of VS is necessary to reach both the nation's fertility objective and the needs of many couples. We also conclude that increased VS adoptions will readily follow enhanced education to the public, to field staff, and to providers. The new emphasis upon reduction of maternal mortality gives a natural basis for a frank presentation of VS to the general public through the media, as well as through personal contacts in communities.

A very large backlog exists of couples who want to cease childbearing, very few of whom now use VS. Many use resupply methods with high discontinuation rates and side effects, and many pill users are past age 35. VS, with its long continuation and negligible failures, can go far to address these problems, to balance offering in the method mix, and to ease the program's cost and reservicing burdens.

That is urgently needed at the present juncture. Contraceptive use remained level at about half of couples after 1987, and essentially no developing country has approached replacement fertility without high prevalence of contraceptive use. That in turn has rarely occurred without substantial sterilization use. Indonesia shows no sign of being an exception, and in any case the VS component is at a decided advantage for attaining both societal and personal objectives.

The 12 recommendations concern action within the new maternal mortality context, training plans, concentration upon critical provinces, the role of PKMI, postpartum programs, reimbursement payments, private sector activity, insurance plans, research, and funding. What is most basic, in our judgment, is a much augmented effort to educate and reassure the public about both tubectomy and vasectomy, to do the same with the field staff cadres, and to address certain features of the services themselves.

Recommendations

1. Initiate mass media for LTM (long-term methods) to reduce maternal mortality.

2. Mount a parallel educational effort at the community level.

3. Reinforce 1 and 2 with augmented training for LTM.

4. To save on cost, discontinue PKMI's training of doctors and provision of equipment in low-performance and small provinces.

5. Continue support to PKMI to protect its core functions.

6. Re-examine the present level of postpartum provision of long-term methods, and rebuild as necessary.

7. Raise the current reimbursement amount to VS service sites, and specify that the doctor is to receive a set amount.

8. Advance private sector activity.

9. Explore the potential for a loan fund to be made available to current health clinics for upgrading or to new health clinics, in both cases those that include family planning.

10. Insurance plans deserve every encouragement. Both ASTEK (JAMSOSTEK) and ASKES offer an interesting potential for VS, without any political risks.

11. Support relevant research, such as: 1) deeper analysis of LTM trends; 2) types of VS procedures (minilap vs. laparascopes, interval vs. post-partum, general vs. local anesthesia, overnight vs. same day discharge) 3) check the reliability of the new MIS; 4) examination of VS side effects data; and 5) a pilot trial of these recommendations.

12. Seek supplementary funding from other sources than USAID, such as the Japanese and Australian governments, and the Asian Development Bank.

43. VS Support Strategy (6/95)

Reynolds, Jack. *"Strategy for Support of VS and PKMI 1995-1999."* Memorandum for VS Communication Technical Committee. Project Support Group, Private Sector Family Planning Project, Bureau of Planning, BKKBN. Jakarta, 30 June 1995.

Topic of study: **VS, PKMI**	Language of original report: **English**
Type study: **Analysis**	Location of report: **USAID**
Duration of study: **January-June 1995**	File name of report: **VSPLANA3**
Location of study: **National**	Date of report: **June 30, 1995**
Study Director: **Jack Reynolds**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Jack Reynolds**

In November 1994 USAID and BKKBN agreed upon a joint strategy to increase the demand for VS and improve VS training and services. USAID has agreed to fund most of the strategy through SDES, PSFP and buy-ins to Cooperating Agencies (SOMARC, JHPIEGO, PCS and AVSC). In early January the Minister issued a paper that outlined a strategy for sustaining VS and PKMI. USAID has also agreed to assist BKKBN and PKMI in this, mostly through technical assistance to study the sustainability problem and develop solutions. This paper is a summary of the overall strategy for all three of these elements: demand, supply and sustainability.

A. Demand Creation and Fulfillment

1. Mass Media Awareness Campaign
2. IEC Campaign to Overcome Fears
3. Improved ISRF System to Increase Acceptors

B. Training and Service Improvement

1. Improved Training of Providers
2. Upgrading of Logistics Systems
3. Development of Quality Assurance System

C. Sustainability

1. Assessment of the Costs and Financing of VS and PKMI

The paper elaborates on these elements and also provides a graphic summary of the VS Communication component of the strategy (Demand Creation and Fulfillment).

44. Evaluation: External QA System (9/95)

Djuarsa S., Sasa, Pinckey Triputra and Jack Reynolds. *"Evaluation of the External Quality Assurance System for Voluntary Sterilization and Other Long-term Contraceptive Services in 12 Provinces of Java, Sumatera and Sulawesi."* The Institute for Mass Communications Research and Development, and University Research Corporation. Jakarta, September 1995.

Topic of study: **VS, LTM, QA, Costs**
Language of original report: **English**
Type study: **Evaluation**
Location of report: **PKMI, USAID, PCS, URC**
Duration of study: **March-July 1995**
File name of report: **QALAP**
Location of study: **West Java, Central Java, East Java, North Sumatera, West Sumatera, South Sumatera, Jogjakarta, Riau, South Sulawesi, North Sulawesi, Central Sulawesi, Southeast Sulawesi**
Date of report: **September 1995**
Study Director: **Sasa S. Djuarsa**
Funding: **PSFP**
Technical assistance: **PSG**
Summary prepared by: **Jack Reynolds**

Background

This evaluation was conducted as part of an overall assessment of Voluntary Sterilization (VS) in Indonesia. It is part of a sub-assessment of family planning quality assurance (QA) systems that have been developed and tested in Indonesia over the past 5-10 years. The results were to be used by a QA Design Team that was formed to recommend an appropriate and sustainable QA system for family planning services in Indonesia.

The External Quality Assurance system (XQA) consists of two major activities at the field level: 1) periodic meetings to review monthly activity reports submitted by the clinics in the province; and 2) site visits to clinics that are having problems to conduct a comprehensive review of facilities, equipment, clinic staff and clinical procedures.

This evaluation was designed and organized in March and April of 1995 and field work got underway in late April. Data were collected from 51 regencies in 12 provinces in Java, Sumatera and Sulawesi. Interviews were held with BKKBN, Depkes and PKMI provincial chiefs, the chiefs of hospitals and clinics where services were provided, with 58 provider teams, and with the team leaders and members of the XQA provincial teams. Field work was completed in three weeks. A preliminary report was presented in mid-June, about two weeks prior to the arrival of the QA Design Team.

Findings

The current XQA program is designed to cover 732 of the 3,848 service sites in Indonesia. The program comes very close to conducting most of the meetings and all of the clinic visits planned in the XQA coverage area. In 1993/1994 that meant that 26 percent of the 732 clinics in the XQA system were visited. But from a national perspective, coverage and visits are quite modest. The system currently covers only about 19 percent of the 3,848 LTM/VS (long-term method/voluntary sterilization) clinics, and only 5 percent of those are visited each year. Only 205 clinic visits were reported for 1993/1994, which averages out to about one visit per province very two months. At this rate it would take 18 years to visit each clinic just once.

There is a great deal of variation among the provinces. The program is larger and more active the more populous the island (i.e., Java is first, then Sumatera, and then Sulawesi). Bali, East Java and Central Java are the most active provinces, in that order. Bali, for example, a LTM province, has 52 clinics, of which 32 are in the XQA system (62 percent). In 1993-1994 the provincial XQA team made 42 visits. That is 131 percent of the clinics in the XQA system and 81 percent of all LTM/VS clinics in the province. But at the other extreme, some provinces conducted few or no visits during this period.

Funding limitations and delays account for some of this. With additional funds many provinces could make additional visits. However, the data indicate that this is not the only limiting factor. Just as important is the lack of time XQA members have to make visits. Also, there is no paid staff to administer the system. Even if the members had more time and the administration of the system could be strengthened, it is expensive as it stands. At Rp. 710,000 per visit on average, it would be extremely expensive to expand coverage and increase the frequency of visits. Roughly, one visit to each of the 3,848 clinics each year would cost Rp. 2.7 billion.

On the positive side, the XQA team leaders and team members appear to be well-qualified and experienced in both quality assurance and supervision. The majority have spent several years working in the XQA system. The fact that they are volunteers and that most have not even thought about dropping out of the system is a good indication of their commitment and dedication to quality assurance.

The XQA system seems to be well-designed, and most of the members follow the procedures carefully. The periodic meetings are held every two months on average and are thought to be valuable. The topics that are supposed to be discussed (results of clinic visits and results emerging from monthly clinic reports) are discussed. The clinic visit protocol is comprehensive. It covers structural items (facilities, equipment, etc.) as well as procedures (counseling, operations, etc.). Direct observation of key procedures is reported to be conducted quite often.

It seems clear that the system has the potential to make a significant contribution to quality improvement. There are a few limitations that were identified which could easily be corrected. Some improvements in indicators could be made so that the teams could better identify clinics that need attention and also compare clinic performance with standards of clinical practice and quality of care. The feedback component needs to be strengthened and a follow-up mechanism added to make sure that recommendations for improving quality are implemented by the providers.

Recommendations

The most serious constraints, however, are that the system is very time-consuming and expensive. It is unlikely that it can be replicated in its present form so that all LTM and VS clinics are covered and visited at least once each year. That would seem to be the minimal requirement if this system were to become the primary mechanism for quality assurance throughout the country. Even if the funds were available to upgrade the system, add support for administrative costs, and expand coverage to all clinics, which is unlikely, there are not enough XQA team members to conduct the minimum number of visits that would be required (around 4,000 per year). And the pool of potential candidates who could serve as members is very small.

The best use of the XQA system may be as a complement to an alternative national system. For example, the QA Design Team has recommended a simple and inexpensive QA system that could be an extension of the clinical training that is now getting underway under the National Resource Center and the National Clinical Training Network. Commitment to quality would be built into the curricula and require no extra training time. Trainees would develop action plans at the end of their clinical training session. Those plans would be complemented by a self-assessment form that the trainees would send back to the trainers at 6 weeks, 6 months and 1 year. The trainer would check performance, provide feedback, and arrange for a site visit, if required. A limited number of "spot checks" or "random visits" would be made by the trainer to the providers who were trained to observe and assess their performance.

The XQA clinic visit form could be modified to be used for these spot checks and follow-up visits. The results of these visits could be fed back to the NRCs, PKMI, Depkes, BKKBN and others for consideration and action at local, provincial and national levels.

45. VS Clinics in Indonesia (10/95)

Reynolds, Jack . *"Voluntary Sterilization Clinics in Indonesia: How Many Are Needed?"* Project Support Group, Private Sector Family Planning Project, Bureau of Planning, BKKBN. Jakarta, October 1995.

Topic of study: **VS, Clinics, Costs**	Language of original report: **English**
Type study: **Analysis**	Location of report: **PKMI, USAID**
Duration of study: **June-October 1995**	File name of report: **VSCLINIC**
Location of study: **National**	Date of report: **NA**
Study Director: **Jack Reynolds**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Author**

Background

This paper was prepared as part of the VS Cost and Financing Study. It is based on data collected by BKKBN for the fiscal year that ended in March 1994. During that year there were 118,152 sterilizations reported from 3,924 clinics. That averages out to 30.1 operations per clinic, about one every two weeks, not counting Sundays. It has long been BKKBN policy to expand services wherever possible in order to increase acceptance and continuous use of contraceptive services.

However, as USAID financial support for voluntary sterilization (VS) draws to a close, and no alternative source of funding has been identified, ways are being examined to cut costs while maintaining a reasonable level of service, so that those people who want to accept VS will have access to this service.

This paper summarizes the results of an analysis of the number of VS service sites. It concludes that at least half of the current clinics can be (and probably should be) closed. This will not only reduce operating and support costs to a significant degree (thereby increasing the sustainability of VS services), but perhaps even more important, will improve the quality of VS services. This can probably be done without jeopardizing access to VS services.

Methodology

PKMI provided the PSG with a printout of the most recent listing of VS clinics that performed vasectomies and tubectomies between April 1, 1993 and March 31, 1994. The printout shows the name of each clinic, its location (province, regency), and the number of tubectomies and vasectomies performed that year. The computer file was obtained from BKKBN and the data were reorganized to show the number of clinics in each province (by regency) that performed 1-6 operations that year, 7-12 operations, and so forth up to 541 and more. The purpose was to identify the clinics that were performing large numbers of operations (and should, therefore, be kept open) and those that were performing few operations (and should, therefore, probably be closed).

One table was prepared for each of the 27 provinces. The figures are shown for each regency in the province and a total summarizes the distribution for the province. The number of cases is also shown for each regency, broken down by vasectomy and tubectomy cases. Percentages are also shown, as are calculations of the average number of vasectomies performed per clinic and the average number of tubectomies performed per

clinic in the province. Since these data come from the same computer file (and printout) that list each individual clinic, it is possible to identify the exact clinics that fall within each range. The names of those clinics can be found in the BKKBN printout.

Finally, two summary (recapitulation) tables were prepared that list the same data for each province, and summarize the national totals. The first table provides the actual numbers of operations and clinics in each range; and the second table provides the percent distributions.

Results

The summary tables show that half of the 3,924 clinics that reported doing at least one VS operation had six or fewer cases the entire year (less than one every two months). Another 14 percent had between 7-12 cases; and another 24 percent had 13-50 cases. Cumulatively, over 87 percent of the clinics performed less than one sterilization per week, 63 percent performed less than one per month, and almost 50 percent performed less than one every two months.

Table 1: Number of clinics and number of acceptors per clinic, 4/93-3/94

Number of cases	1-6	7-12	13-50	51-100	101-260	261-540	> 540	Total
Number of clinics	1,927	562	944	263	165	41	22	3,924
Percent of clinics	49.1	14.3	24.0	6.7	4.2	1.0	0.5	100.0
Cumulative percent	49.1	63.4	87.4	94.1	98.3	99.3	99.8	

There are significant variations, of course, by province, by regency and by clinic. For example, 8 of the provinces had large numbers of clinics (70 - 86 percent) that performed few operations, but three provinces had much smaller proportions in that category (30 - 39 percent). Bali may have the most efficient system. Of its 25 VS clinics (one of the smallest number, especially given the size of its population), 20 percent perform 100 or more operations per year, and only 36 percent perform less than 6 per year (the second lowest percentage of all 27 provinces). Jabar had the largest number of VS cases, over 28 thousand. But it was close to the average of low-performance clinics (41 percent of its 992 clinics only performed 1-6 procedures, for example).

Discussion

It should be clear that at least half of the VS clinics should be closed. There are two reasons for this: inefficiency and quality. The cost of maintaining a VS clinic is very high. Staff training, quality assurance/supervision, and equipment are all expensive. Where there is rapid turnover of staff, the clinic may not be operational because the physician who was trained last year has left. It is extremely costly to train replacement staff in rapid turnover clinics, such as health centers in rural areas.

The second issue is even more important. Clinicians (doctors, midwives, nurses, anesthesiologists) need practice to keep their skills up to an acceptable standard. If facilities (or practitioners) cannot perform at least 20 cases per year,[11] they are not likely to

[11] This is an educated guess. No guidelines have been developed regarding the minimum number of operations needed to retain proficiency.

keep their skills. And this can have serious consequences with respect to quality of care. It is not only inefficient for such people to perform VS operations, it is dangerous. Side-effects, complications, even disability and death are more likely when surgical operations are performed by providers with limited or no experience.

The number of operations performed is only one criterion that should be used to decide which sites to close and which to keep open. PKMI and BKKBN should examine the distribution of VS service sites in each province and prepare provincial-level plans for reducing the number of sites to the number needed to provide adequate coverage of demand for VS.

46. VS Cost Containment Recommendations (11/95)

Prihartono, Joedo. *"Sustainable Voluntary Sterilization Recommended Cost Containment Actions,"* University Research Corporation, Jakarta, November 1995.

Topic of study: **VS, PKMI, Costs**	Language of original report: **English**
Type study: **Analysis**	Location of report: **YKB**
Duration of study: **July-November 1995**	File name of report: **NA**
Location of study: **National**	Date of report: **November 1995**
Study director: **Joedo Prihartono**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Author**

Background

The Indonesian Voluntary Sterilization program is still not an official part of the national family planning movement. This program, which is coordinated by PKMI, is completely dependent on the availability of international financial support. USAID, which has been the main funder of the program for the last 21 years, will be phasing out in the next three years.

This consultancy report highlights several possible options in cost containment for the voluntary sterilization program as well as for PKMI activities. The review was conducted on the available secondary data, which have been compiled by various institutions and investigators. Special appreciation is directed to the various parties who have provided necessary information for this consultancy.

Indonesian VS Situation

- The current supply side of the VS program is abundant. The number of registered health facilities with operating theaters and trained VS operators has grown dramatically.

- Monthly feedback shows that most of the health facilities performed only limited procedures. This created inefficiency, high costs, and diminishing medical skills, which can lead to higher complications.

- For each vasectomy procedure there were five to six tubectomy procedures. Vasectomy is cheaper, safer, easier and simpler, thus the current program is more expensive than expected.

- In performing tubectomy procedures, more general anesthesia is used. General anesthesia is more expensive, has higher complication risks, and needs more equipment compared to local anesthesia.

- OB/GYNs preferred the use of laparascopes compared to minilaparatomy. It is more expensive, needs more training, and requires more equipment.

PKMI Situation

- PKMI currently is completely subsidized by international donors in operating its activities.

- The calculation of the unit cost for each VS procedure in Indonesia is rather expensive.
- Some of the subsidized activities at PKMI are currently duplicative, such as cleaning service and security service.
- The existing model clinic still needs a high subsidy and does not show promising prospects in the near future.
- PKMI does not have previous experience in institutional entrepreneurship. Recently, PKMI developed some ideas of income generating activities, such as becoming the sole O-ring importer, prepaid RAM services, and profitable clinics. However, the idea of O-ring sole importer will not work since the major buyer is still BKKBN.

Recommended Cost Containment

- The re is a need to establish a sustainable VS program to pursue the population goals and objectives.
- There is a need for a strong, self-reliant NGO to assist BKKBN in coordinating the unofficial VS program.
- Reduction of operational costs and enlargement of generated income are essential to reach the break-even point.

Reduce Operational Cost of PKMI Activities

- Gradual transfer of current activities to BKKBN and/or POGI through the NRC channel. In the future the role of professional organizations will be greater in providing direct services. PKMI has developed the necessary standards.
- Reduce gradually the number of PKMI personnel in line with the gradual transfer of activities. With fewer activities, PKMI will need a smaller organization, too.
- Focus the PKMI role more on administrative and coordination aspects in assisting BKKBN. Since most of the needed standards and manuals have been developed by PKMI, thus, in accordance with its expected position, PKMI should focus more on the administrative aspects.

Increase Generated Income for PKMI

- Start charging a tuition fee for VS training. The current free training service is a potential source of PKMI income.
- Start a maintenance contract scheme for laparascope repair and maintenance. To overcome the vast geographical distribution of this medical equipment, PKMI's RAM centers should train local technicians and charge the participating hospitals a tuition fee.
- Establish self-reliant, comprehensive clinics. VS services may not attract enough clients for the clinic to become self-reliant. Combining VS with various other health and FP services will be more attractive.

- Look into endowments and a "pengayoman" as possible funding sources. PKMI should discuss with BKKBN in appealing to Bappenas for the opportunity to manage the VS funds according to an endowment-like approach.

- Charge a commission for processing the government VS subsidy. Currently and prospectively, the government provides a subsidy for VS procedures. PKMI should ask for an opportunity to become the sole administrator of this fund, and ask for a percentage commission.

- Charge overhead or an institutional fee for future investment. Currently, PKMI operates on a project basis with a zero budget balance. To give an opportunity for future investment, PKMI must establish its fund revenues by asking overhead costs or an institutional fee for each project.

Reduce Operational Cost of VS Program

- Close VS clinics with very few clients. Clinics with very few clients waste the limited resources and tend to cause more complications due to lack of enough practice. By closing these clinics and concentrating on busier clinics, the VS program will reduce costs.

- Start paid training, paid IEC material and installment payments for medical equipment. The private sector should start to shoulder the cost of training, IEC material and medical equipment. The VS program should assist the private sector in procuring these services.

- Focus on vasectomy, local anesthesia and minilaparatomy. Vasectomy is cheaper and safer, thus should be offered more than tubectomy. The use of local anesthesia is cheaper and safer compared to general anesthesia. Laparascope needs special professionals and training to operate.

- Attach VS to multi-purpose clinics. VS service must be attached to existing multi-purpose clinics to reduce unit costs and attract more clients.

- Reduce the subsidy to service facilities and encourage them to become self-reliant. The 1994 IDHS shows that the private sector actually profits from VS services and thus does not need future subsidies.

Strengthen Existing Sources of Funds for VS Programs

- Create a bigger market through a Blue Circle-like approach for VS. The Blue Circle program did very well in attracting more clients and private sector participation, and has been expanded into the Gold Circle program. This approach will also have a positive impact on VS demand.

- Let the market system thrive for the private sector. The private sector will spontaneously invest their resources if they see profitable opportunities. By deregulating the VS program, the government may attract the private sector.

47. Quality of Mobile VS Services (11/95)

Roestam, Ambar W., Anindiarti, Dwi Wahyuni, Sylvia Pangemanan. *"Quality Sterilization Services through Mobile Service Teams."* Department of Community Medical Sciences, Medical Faculty, University of Indonesia. Jakarta undated (November 1995).

Topic of study: **VS, QA**	Language of original report: **Indonesian**
Type study: **Evaluation**	Location of report: **PKMI**
Duration of study: **June-November 1995**	File name of report: **NA**
Location of study: **East Java, Southeast. Timur, South Sumatera**	Date of report: **November 1995 (draft)**
Study Director: **Ambar W. Roestam**	Funding: **PSFP/SDES**
Technical assistance: **NA**	Summary prepared by: **Author**

Background

Voluntary sterilization (VS) is different from other contraceptive methods in that it requires an operation. Besides that, it involves risk. Theoretically, when the procedure is carried out by a mobile team, the risk is even higher. A total of 28.4% of VS acceptors get their service from a mobile team (compared to 5.9% for all methods). There remains a question, therefore, about the level of quality of VS provided by mobile teams.

The objectives of this study are: (1) to obtain a picture of the quality of services provided by VS Mobile Teams; (2) to obtain a picture of the factors that influence their quality, that is input, process and output factors; and (3) to formulate recommendations to improve the quality of VS Mobile Team services.

Methodology

This research is cross-sectional, and was undertaken in three provinces: East Java, West Sumatera, and Southeast Timur. Two regency that provide VS services were selected randomly from each province. Data were collected through observations, in-depth interviews and interviews with VS acceptors who received their service from VS Mobile Teams. Medical records were examined and other secondary sources were used, as well. The sample is made up of (1) 26 policy makers from the provincial and regency level; (2) 44 Mobile Team providers, made up of an obstetrician, GP, nurse/midwife and counselor; (3) 90 family planning field workers; (4) 363 VS acceptors operated on by Mobile Teams; (5) 363 medical records; and (6) 14 tubectomy and 4 vasectomy cases to observe the medical procedures.

Findings and Conclusions

In general, the policy makers, field workers and the Mobile Teams are highly aware of service quality. Nevertheless, not yet all of the factors that affect service quality have achieved set standards. Service quality from the perspective of the client indicates that they pick the Mobile Teams because they are accessible and cheap, and they are quite satisfied if the provider shows a friendly attitude. Completion of the medical records requires special attention. Service quality from the perspective of the policy makers indicates that the Mobile Team service fulfills the program objectives, safely, professionally, and by providing easy access to far away communities.

Recommendations

It is suggested that efforts to improve the quality of Mobile Teams begin with concern for the views of all sides, from the policy makers and Mobile Team members to the community itself. Although the people are quite satisfied with the services that are provided, it is recommended that efforts to increase quality stress the importance of a continuing process, so that the service standards can be fulfilled as expected.

48. Evaluation: PKMI Internal QA Pilot Project (12/95)

MacDonald, Patricia and Maria Francisco. *"Internal Quality Assurance: An Assessment of the PKMI Pilot Project."* University Research Corporation. Jakarta, December 1995.

Topic of study: **VS, QA, Costs, PKMI**	Language of original report: **English**
Type study: **Evaluation**	Location of report: **PKMI, URC**
Duration of study: **May 1992-March 1995**	File name of report: **NA**
Location of study: **Jakarta & West Java (16 hospitals)**	Date of report: **December 1995**
Study Director: **Azrul Azwar**	Funding: **PSFP, URC/QAP**
Technical assistance: **PSG, URC/QAP**	Summary prepared by: **Jack Reynolds**

Background

As part of its activities under the Private Sector Family Planning project (PSFP), PKMI developed and conducted a pilot test of an Internal Quality Assurance program in 16 hospital family planning units between May 1992 and March 1995. This system was meant to complement the External Quality Assurance system[12] by providing hospital staff to assume more responsibility for the quality of services they provide.

The basic concept was to train multidisciplinary teams to identify problems, set priorities among them, define a selected problem carefully, analyze it, develop one or more solutions, implement and assess those solutions, and then move on to the next problem, repeating the cycle.

PKMI played a dual role in the project, first as the manager of the pilot project, and second as the principal source of technical assistance to the hospitals. PKMI staff provided formal training and on-site technical assistance to each of the hospital teams. Technical assistance was also provided to PKMI by international consultants from URC's Quality Assurance Project (QAP) and the Project Support Group (PSG) of the PSFP project.

The IQA Program

PKMI and the international consultants spent the first year of the project developing, testing and revising a Quality Assurance manual, which served as the basic document for the IQA system. In April 1993 hospital and family planning unit directors attended one-day QA awareness workshops to develop their understanding of and support for the QA program. Each of the hospital directors then appointed an internal multidisciplinary team (averaging 8-13 members) to carry out the test. Three members of each team attended a five-day QA Basic Skills Course conducted by PKMI. These participants were supposed to train the other members of their team when they returned to their hospitals. Then they and the hospital directors were to conduct one-day QA Orientation Seminars for the entire hospital staff.

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[12] See Sass Djuarsa, Pinkey Triputra and Jack Reynolds. *"Evaluation of the External Quality Assurance System for Voluntary Sterilization and Other Long-term Contraceptive Services in 12 Provinces of Java, Sumatera and Sulawesi."* Lembaga Penelitian dan Pengembangan Komunikasi Massa (LPPKM). Jakarta, September 1995.

Once all of this orientation and training was completed the teams were expected to implement the QA cycle described above, starting with team meetings to identify, prioritize and analyze problems. PKMI provided on-site technical assistance during the entire cycle, making an average of 10 visits to each hospital.

Revisions in the Design

For a variety of reasons, the original design of 10 experimental and 10 control hospitals changed over time. The controls were dropped and a "case study" approach was implemented instead. One hospital dropped out, seven new ones were added in 1994, and four of the 16 participating hospitals either did not start or provided no data for the analysis.

An Interim Evaluation of the project was conducted in January 1994 and one of the recommendations was to strengthen the technical and facilitation skills of the PKMI facilitators. A QAP consultant visited Indonesia in May 1994 to conduct such a course. Changes were also made in the manual and training, for example, to add case studies and place more emphasis on using data to analyze problems.

Implementation of QA Activities

The teams took an average of 2 ½ - 3 months to identify, prioritize and select a problem to work on. They spent another 2-6 months to analyze the problem and its causes. They took 3-6 months more to develop, implement and monitor solutions. Only 9 of the 16 teams completed a problem-solving cycle. Personnel issues had a significant effect on the teams. Some hospital directors were transferred. Team leaders were usually the head of the OB/GYN or Family Planning unit, and sometimes were too busy to attend team meetings. Team members not involved in FP lost interest. Teams seemed to meet and move forward in direct response to PKMI site visits.

Although the teams used many of the concepts and tools they learned in training, and PKMI technical assistance was very helpful, most of the teams had difficulty with each step, especially identifying and understanding problems. This was due, in part, to lack of understanding and analytical skills and in part to lack of participation or interest of key staff, especially the team leader. Both the problems identified and the solutions proposed were sometimes simplistic. For example, one team identified a problem as "80 percent of FP clients do not return for follow-up visits," the cause as "low knowledge, insufficient money, counseling, posters," and the solution as "train staff, get posters, give counseling." However, in other cases, the problems, causes and solutions were impressive. For example, the team at Marinir Cilandak hospital reduced the number of clients who weren't served at the clinic by increasing the number of days for FP services and by giving mothers at the maternity unit FP referral cards.

Conclusion and Recommendations

There is a great deal of interest in QA, and PKMI was very active in both promoting that interest and in providing training and technical assistance to help hospitals develop and run their own internal QA programs. Yet, few of the teams that expressed interest in the concept have carried the process through and been able to realize significant and sustained improvements in service quality as a result of the QA program. Moreover, for those teams that did achieve improvements, it is not certain that they will continue with the program.

The teams will need to develop stronger analytical skills in problem solving if this system is to be run internally. Sustained commitment of hospital leadership and consistent involvement of team leaders are basic requirements, as well. If PKMI wishes to function as a QA consulting agency, it must also strengthen its ability to provide QA training and technical assistance, and it must broaden its expertise beyond family planning to develop a hospital-wide QA structure.

In conclusion, the PKMI Internal QA program should not be replicated in its present form. Rather, the program needs to be restructured to encompass all components of an organization (not just family planning) and to aim from the outset to construct a self-sustaining system (not one that is externally driven). This will require a systematic, yet flexible approach to QA, a comprehensive perspective of the scope of the QA system, an overt and visible commitment from the organization's leadership, the creation of dedicated and qualified coaches within the institution, and the development of a similar cadre of qualified QA consultants within PKMI.

49. Financing VS through JPKM (12/95)

Marzolf, James R. "Financing Long-term Family Planning Methods through JPKM Managed Care." University Research Corporation, Jakarta, September, 1995

Topic of study: **VS, LTM, JPKM, PKMI**	Language of original report: **English**
Type study: **Analysis**	Location of report: **PKMI**
Duration of study: **August-September 1995**	File name of report: **NA**
Location of study: **National**	Date of report: **September 1995**
Study Director: **James R. Marzolf**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Jack Reynolds**

JPKM (*Jaminan Pemeliharaan Kesehatan Masyarakat*) is a relatively new health care financing strategy developed by the Department of Health (*Depkes*). It is not a health insurance scheme, as is often thought, but a managed care strategy. Health insurance reimburses the person insured for all or part of the costs that the provider charged for services covered by the health insurance policy. In the JPKM strategy employers or members make a monthly contribution to a JPKM company which contracts with one or more health care providers (clinics, hospitals) to provide the members with an agreed upon package of health services - at no additional charge. The providers receive a set amount from the JPKM company (a capitation fee for each member covered) in return for guaranteeing to provide the members with the health services agreed upon.

The importance of JPKM for family planning, especially voluntary sterilization (VS), is that this program guarantees all employees and their dependents access to family planning services from private providers at no additional cost. Under the current manpower regulations[13] all employers must provide health care for their employees and dependents that is equal to or better than the benefits package of PT Astek; and under the current health regulations, all JPKM programs must provide family planning as part of the basic benefit package. This includes vasectomy and tubectomy.

This paper describes the differences between JPKM and other programs in some detail, and carefully examines the costs of including family planning services in JPKM, especially long-term methods, and sterilization, in particular. The analysis concludes that for Rp 319 per member per month (Rp 3,828 per year, or $1.67) the current contraceptive service and method mix pattern (15% injectables, 10% IUD, etc.) could be financed at full costs. All of the long-term method services cost only Rp 99 of that Rp 319. (about 31%).

The paper also describes the economic advantages of this program over the current government subsidy program, the current government insurance program (e.g., Askes), the government's health card program for the poor (Kartu Sehat) and such financing schemes as installment payments. In fact, the government plans to replace its subsidies, Askes insurance and the health card programs with JPKM.

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[13] See the National Health Law (UU #23, 1992), the National Worker's Security Law (UU #2, 1992), and related regulations.

The total enrollment in JPKM in 1995 is only about 16 million, or 8-9% of the population. But it is projected to rise to 31 million by 2000 and then to grow rapidly over the next five years to 170 million, or 76% of the total population. The percentage of eligible women aged 15-49 who will be covered for family planning will reach 73% in 2005.

Enrollment and coverage will not be evenly distributed geographically, nor will they occur at the same pace throughout the country, but will parallel economic development. Projected overage per province in 2005 ranges from 100% (Aceh, Riau, Jakarta, Bali, Kaltim) to less than 30% (NTB, NTT, Southeast Sulawesi, Maluku). The areas with lower and slower development will require larger government subsidies for longer periods of time for their family planning and health care services.

The government is assuming that people in middle and upper income brackets will take care of themselves, with regard to enrollment in JPKM programs. This is because of market forces and the manpower regulations. This "private sector" enrollment will reach about 12 million by 2005. Another 37 million are expected to be enrolled in an Astek JPKM program, and some 14 million more will be covered in the Askes JPKM scheme.

The biggest group to be covered are the millions of lower income people in the informal sector and rural areas. The government is testing a "Regional Basic Benefits Package" (RBBP) for this group. The pilot scheme is currently in its second year of development in Klaten Regency in south Central Java. Klaten has a population of 1.1 million of whom 60% have been targeted for enrollment in the RBBP. It has been projected that 12,000 participants will have been enrolled by the end of 1995. Enrollment is expected to reach 67,000 by the end of 1996. Once this pilot is optimized, the Ministry of Health plans to replicate it in other regencies. A number of regencies in 5 provinces under the World Bank HP IV project and in 4 provinces in Sumatera under the ADB II project have been selected as replication sites. The third phase of the strategy calls for the initiation of the RBBP wherever it is suitable. It is on the basis of this multiple replication pattern that the enrollment is projected to reach 1.7 million by 2000 and then essentially double each year thereafter, reaching 106 million by 2005.

JPKM is not yet well known or understood. The Ministry of Health is just beginning to educate its own staff to the program. There are no plans as yet to educate BKKBN staff about the program, and in particular, its benefits for family planning service provision and the promotion of KB Mandiri. An educational and promotional program for family planning administrators and employers would be timely to ensure that full advantage can be taken of this new health sector financing program.

50. VS Social Marketing Results (12/95)

The Futures Group, SOMARC Project. *"Project-End Report: Indonesia Voluntary Sterilization Social Marketing Program 1995."* Submitted to USAID/Jakarta, December 1995.

Topic of study: **VS, SM**	Language of original report: **English**
Type study: **Evaluation**	Location of report: **TFG, USAID**
Duration of study: **October-December 1995**	File name of report: **NA**
Location of study: **Jakarta, Surabaya**	Date of report: **December 1995**
Study Director: **Robby Susatyo**	Funding: **Somarc**
Technical assistance: **PSG**	Summary prepared by: **Author**

Voluntary Surgical Contraception is a family planning method that is not popular in Indonesia. Acceptance is as low as 3.8% whereas CPR of modern FP methods is 52%. Reason for the low VS prevalence are low public awareness, fear of side effects and opposition by influentials -- particularly the Moslem leaders.

TFG/SOMARC designed a mass media advertising campaign to address the issues. However, the Indonesian government, i.e.,. BKKBN advised us that such an approach might work counter productively and might jeopardize the entire success of the Indonesian Family Planning Program. With the directive from the Minister of Population, we adjusted the mass media campaign to a series of public relations activities and combined them with a lead generation direct marketing print ad in selected newspapers and magazine that invited readers to call a hotline number for free consultation about secure contraception.

The public relations activities comprised of seminars and dialogues among the press, health practitioners, Islamic teachers, and business executives generated a total of 49 print articles in leading newspapers and magazines. The articles elaborated detailed factual information about VS. The press mentioned hundreds of times the terms Tubectomy and Vasectomy, benefits of VS ("Mesra"), Maternal Mortality Rate reduction, religious views and endorsement, government support, information of service points, procedures and costs of VS, and testimonies from satisfied users dispelling the myths of after-effects.

The response to the print ad generated over 700 telephone calls within six weeks. An opportunity was created to talk to potential acceptors who had been screened by the language in the body copy of the ad. About half of the callers who said they were interested had been referred to VS hospitals and clinics near their homes. A few have actually come to PMI's clinic to be vasectomized.

The project has demonstrated within a short period that with a relatively small budget (circa $100,000), a focused social marketing/publicity approach was able to raise awareness, enhance public interest, and secure the support of influentials. The lessons learned here are adaptable to other social marketing challenges that we are facing in Indonesia, as well as other countries around the world.

51. VS Service Data (12/95)

Vogel, Russell. *"Basic Survey Data on Kontap."* Based on data collected by the Private Sector Family Planning Project. Project Support Group, Private Sector Family Planning Project, Bureau of Planning, BKKBN. December 1995.

Topic of study: **VS, LTM**	Language of original report: **English**
Type study: **Analysis**	Location of report: **PKMI, USAID**
Duration of study: **November-December 1995**	File name of report: **NA**
Location of study: **National**	Date of report: **December 1995**
Study Director: **Russ Vogel**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Jack Reynolds**

This report summarizes and presents data collected in late 1995 from seven provinces on the distribution of sterilization cases by type, timing, procedure, and anesthesia. The data were collected as part of the "VS Cost and Reimbursement Study" conducted by the Pusat Penelitian Kesehatan, Lembaga Penelitian, Universitas Indonesia and staff of the Project Support Group (PSG) of the PSFP project.

The data come from lists of sterilization cases conducted over the previous 12 months in each of the 38 hospitals and clinics included in the study. Up to 50 of the most recent cases were to be selected and classified by type sterilization (vasectomy, tubectomy) and for tubectomies, by timing (postpartum or interval), procedure (minilap or laparascope), and anesthesia (general or specific). In most cases the number of cases did not reach 50. This is partly because some of the field investigators used 25 cases as the cutoff and many clinics did less than 50 procedures in the previous 12 months. In some clinics the reports were incomplete, so that all of the data needed could not be collected. In 13 of the 38 clinics there were no reports or data at all.

Although the data are limited and their representativeness is unknown, they were summarized and distributed to a small group of program officials because they are the only data of this kind that has been collected. The summaries are shown here. They show that the most popular are tubectomies done between pregnancies, using minilaparascopes and general anesthesia. The policy recommendations regarding the latter are minilaparascopes and local anesthesia.

Type operation	N	Percent
Vasectomy	89	13.4
Tubectomy	576	86.6
Tubectomy timing		
Postpartum	154	26.7
Interval	422	72.3
Tubectomy method		
Laparascope	169	30.8
Minilap	380	69.2
Tubectomy anesthesia		
General	338	68.0
Local	159	32.0

52. Evaluation: IISRF System (1/96)

Roestam, Ambar W. and Dewi S. Soemarko. *"Evaluation of the IISRF System, Voluntary Sterilization Program, SDES Project, Year One."* Department of Community Medical Sciences, Faculty of Medicine, University of Indonesia. Jakarta undated (January 1996).

Topic of study: **VS, QA**	Language of original report: **Indonesian**
Type study: **Evaluation**	Location of report: **PKMI**
Duration of study: **September 1995-January 1996**	File name of report: **NA**
Location of study: **30 clinics in 10 provinces, Jakarta, West Java, East Java, South Kalimantan, West Kalimantan, South Sulawesi, North Sumatera, South Sumatera, West Nusatengara, East Nusatengara**	
	Date of report: **January 1996 (draft)**
Study Director: **Ambar W. Roestam**	Funding: **SDES, PSFP**
Technical assistance: **PSG**	Summary prepared by: **Jack Reynolds**

The IISRF (Identification, Information, Screening, Referral, Follow-up) system was first tested as an operations research project in four provinces between 1988-1991. The system was designed to improve the ability of front-line workers to work with candidates for Voluntary Sterilization (VS). The system was included in the PSFP VS Social Marketing operations research project in 1992-1994, which was tested in 26 clinics in Jakarta and East Java. It was also incorporated into the SDES project in 1994, and covered 212 clinics in 14 provinces.

This is the first evaluation of the system, and the sample was designed to cover both the PSFP and SDES sites. A total of 30 clinics were selected from 10 provinces. A total of 216 interviews were conducted with field workers, service providers and VS acceptors.

Findings

In general, most of the front-line workers (FLW) thought that the system required a good deal of effort to implement but that it works well. They rated the training and materials they received as generally good.

For the **Identification** step, most used the various registers available to the, especially the Family Welfare and field worker registers.

The part of the system that took the most effort was providing **Information**. To do that the FLW needed IEC material and teaching aids and had to work with potential acceptors one at a time. The most valuable IEC material was the leaflets on vasectomy and tubectomy. The FLWs thought that they did not have enough skills to use the teaching aids effectively. That was due, in part, to the short duration of training, which was only one day. They also thought that they needed training in communication techniques and overcoming socio-cultural barriers.

Screening was relatively easy and fast, and they were able to use the health facilities for this.

The **Referral** step was also relatively easy and worked well. The workers did not have any problems filling out the referral forms.

Follow-up was divided into that done by the field worker and that done by the clinic. In most cases the field workers contacted VS acceptors after the operation and then made referrals, if needed, back to the clinic to deal with complications or to have their semen checked. This part of the system also seemed to work well.

Periodic meetings of the FLW, supervisors and providers are useful for improving coordination, sharing information, overcoming problems and creating motivation.

Most of the VS acceptors interviewed (89%) were satisfied with the system. In general, it seems to have improved the quality of VS services, and increased the acceptance of VS. At the 22 SDES clinics, the FLWs contacted and provided information on VS to 46,156 potential candidates. From that group 3,469 were referred to clinics for VS operations.

Recommendations

- The IISRF system should be continued, as it increases the quality of services.
- Training should focus on improving the communication skills of the FLW, including their ability to use the teaching models effectively. The time allowed for training should be expanded.
- To simplify the screening process and reduce problems in the field, the village midwives should become involved in screening.
- Home visits by the FLWs need to be intensified to improve the quality of follow-up and to broaden it to include social in addition to medical aspects.
- The periodic meetings should be continued, and
- To achieve the overall objective of the IISRF system, to increase the total number of VS users, information needs to be made available through all channels, electronic, print and all other mass media.

53. Costs and Financing of VS in Indonesia (2/96)

Reynolds, Jack, et al. *"The Costs and Financing of Voluntary Sterilization in Indonesia."* Project Support Group, Private Sector Family Planning Project, Bureau of Planning, National Family Planning Coordinating Board. Jakarta, February 1996

Topic of study: **VS, Costs, PKMI**	Language of original report: **English**
Type study: **Analysis**	Location of report:
Duration of study: **September-December, 1995**	File name of report: **NA**
Location of study: **National**	Date of report: **NA**
Study Director: **Jack Reynolds**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Author**

The general **objective** of the study reported here is to determine the actual monetary costs of VS in Indonesia and identify alternative ways to finance those costs at three levels: provider costs, PKMI costs, and total costs of the national program. Several substudies were undertaken to gather the data needed and to analyze various cost-reduction and financing alternatives. The most important of these were:

- VS Provider costs and reimbursements
- Client VS costs
- VS subsidy costs (BKKBN)
- VS support costs (PKMI)
- Numbers and productivity of VS clinics
- Cost containment options for VS and PKMI
- Financing mechanisms, and
- VS Cost and financing strategies

VS Service Costs

What does a VS operation really cost? How much are clients paying for an operation? How much do providers receive for each VS operation? Are they losing money, breaking even, or making a profit? The average tubectomy costs Rp 97,032 and the average vasectomy Rp 56,586. Private providers receive an average of Rp 306,495 per tubectomy and Rp 172,186 per vasectomy, for a profit of Rp 209,463 and Rp 115,600 respectively. Public sector providers receive much less, but still make a small profit on average: Rp 3,377 per tubectomy and Rp. 12,557 per vasectomy.

VS Support Costs

Because VS is not a part of the national program, PKMI's role has been to provide or arrange for almost all VS support services to providers, policymakers and others involved in the development and operation of the VS program in Indonesia. This includes education and training, infrastructure (facilities and equipment), quality assurance, community relations, development and testing of new approaches, reimbursement, as well as coordination and supervision.

To support these activities, PKMI requires an annual budget of Rp 6,133,390,025. About 90 % of PKMI's budget is for program activities, coordination meetings and supervision.

Only 10% goes to administration and personnel. The major program activities are the IISRF system (30%), training (26%), services (20%) and equipment (13%). Up to now, practically all of PKMI's financial support has come from one source, USAID.

Total VS Program Costs

The total cost of the VS program is Rp 17.2 billion per year. These costs consist of unreimbursed costs to the providers, BKKBN reimbursements to providers, and PKMI support service costs. The total cost to the GOI is somewhat less, Rp 15.5 billion, when unreimbursed private sector costs are taken out.

Table 2: Estimated Program Costs for VS Services and Support Activities (in 000 Rupiah, 1994/1995)

Category	Rupiah (000)	Percent
Provider costs (unreimbursed)	6,607,926	38.5
BKKBN reimbursements	4,428,840	25.8
Subtotal: VS service costs	11,036,766	64.3
PKMI support costs	6,133,390	35.7
Total VS program costs	**17,170,156**	**100.0**
Unit Cost per acceptor	132,078	

If client payments to public sector providers are used by the clinics and hospitals to offset VS service costs, then that would reduce the net cost to the government another Rp 6 billion, to Rp 9.5 billion. Up to now the actual GOI outlay has been less than this because USAID has provided the GOI with the funds to support all of PKMI's support costs. So the actual net outlay of the government has been Rp 6.1 billion less, or between Rp 9.4 billion and Rp 3.1 billion, again depending on how client payments are allocated.

Cost Containment Opportunities

Table 2 shows that Rp 5.6 billion could be saved by implementing five strategies. By implementing only two of them, reducing the number of VS facilities and eliminating subsidies to the private sector, Rp 3.6 billion could be saved.

Table 3: Estimated Savings from Selected Cost Containment Strategies (in Million Rupiah, 1994/1995)

Strategy	Amount of change	Savings (Rp million)
Reduce VS facilities 25%	reduce 25%	1,100
Vasectomy instead of tubectomy	35,000 cases	1,400
Mini-lap instead of laparascope	30,000 cases	450
Local instead of general anesthesia	30,000 cases	180
Eliminate subsidies to the private sector	all	2,500
Total		**5,630**

Another Rp 2.3 billion could be saved by eliminating special projects now funded by PKMI.

Not all cost containment strategies within PKMI will affect the overall cost of the VS program. Instead, they would reduce PKMI operational costs to a level that can be supported by its revenues. The greatest savings would come from transferring routine PKMI support activities to other agencies, such as the NRC and BKKBN. This would reduce PKMI costs Rp 3 billion.

Financing Options

The best option for financing VS services in the short-run is to make sure that government VS facilities use patient charges for VS to offset their VS operating costs, BKKBN reimbursements, or PKMI support services. This could reduce GOI VS costs by Rp 1-6 billion per year. The best long-run options are to encourage the private sector to take primary responsibility for VS. Increasing demand for private sector VS, encouraging internal cross-subsidies in the private sector, and making sure that VS is included in managed care programs (JPKM) are the most promising options. JPKM, in particular, has the potential to finance 75% of all VS services by 2005.

Options that are not recommended are: increasing service fees (especially in the public sector), increasing government subsidies (except to replace USAID funding for VS support services), incorporating VS in health insurance and health card schemes, and promoting installment payments.

All of the options for PKMI financing are based on a general conclusion that PKMI is not sustainable as currently structured and that the best prospects for PKMI in the future are as an independent, non-profit, technical consulting firm. PKMI can still function as the primary advocate of VS and the primary source of expertise and information about VS. But it will need to reorganize and reorient itself to market and sell its services, primarily to the private sector, but also to donor and government agencies.

The most attractive opportunities for PKMI financing appear to be in VS training of and technical assistance to private sector providers, and contracts and grants for special research and demonstration projects from multilateral donors and the GOI. PKMI should also restructure its accounting system to include indirect costs and fees. Two ideas that need careful scrutiny before they are implemented are the establishment of RAM Center Service Contracts and comprehensive health clinics that also provide VS and other family planning services. Endowments have been suggested, but do not seem to be a feasible option.

Financing Strategies for VS and PKMI

It is time to accept that VS is, and will remain, a minor method in the Indonesian program. This is due to the lack of demand, the constraints on open promotion of the method, and the emergence of attractive, easily accessible and reversible alternatives in the new IUDs and implants.

As this report has shown, the cost of maintaining the current VS service and support system is very expensive and many facilities are underutilized. There is no reason to maintain, much less expand, this service system while demand remains low. It is not only inefficient, but it is potentially dangerous. Providers need to perform a minimal number of operations each month in order to maintain their skills.

If BKKBN wishes to maintain the system as is, it will need to increase its support by up to Rp 6 billion per year just to replace USAID support costs to PKMI. So far, there is no plan to do that. What is needed immediately, is a financing strategy for VS and PKMI. The objective suggested here is to support high-quality VS services in enough sites in Indonesia to enable those men and women who want to adopt this method to have reasonable access to a reasonably priced service.

BKKBN can achieve that objective by adopting the following financing strategy.

1. **Restructure the entire reimbursement and subsidy system** to shift these resources from the private sector (which does not need them) to the public sector (which can use them to subsidize more pre-Mandiri VS clients). At the same time, make sure that client payments received by public VS clinics are used to offset VS service costs. These two measures would allow the GOI to cover the costs of serving 130,000 to 150,000 new acceptors per year at no additional cost.

2. **Reduce the number of service sites,** improve efficiency and quality. By reducing the number of VS facilities by 25%, at least Rp 1.1 billion could be saved in support costs alone (training, equipment maintenance, quality assurance, etc.). This does not include fixed provider costs for keeping the clinics open (staff time, utilities, inventories of drugs, supplies, space, maintenance, administration, etc.). The total savings could well be over Rp 2-3 billion.

   Combined with this, we would suggest implementing as many of the changes recommended in service delivery policy as possible: more emphasis on vasectomy, more use of local anesthesia, more use of mini-lap, and more post-partum sterilizations. That could result in an additional savings of Rp 2 billion.

3. **Promote the development of managed care programs that include VS** and other family planning services. Of all the financing options discussed, the JPKM managed care strategy offers the most advantages in the long run. By the year 2005 almost 170 million Indonesians (75% of the population) are expected to be enrolled in a JPKM program. All men and women of reproductive age in this group will be eligible to receive high quality family planning services (including VS) from private providers at no additional cost other than their monthly contribution to the JPKM program.

   In support of this recommendation, BKKBN and PKMI should encourage providers to set up comprehensive health clinics (rather than specialty VS or family planning clinics) that offer VS and other family planning services. This will expand access to all such services and help to increase awareness and use of VS.

4. **PKMI** should transfer its routine VS activities to the GOI and restructure itself as an independent, non-profit, technical assistance consulting firm. The most attractive opportunities for PKMI financing appear to be in VS training of and technical assistance to private sector providers, and contracts and grants for special research and demonstration projects from multilateral donors and the GOI. PKMI should also restructure its accounting system to include indirect costs and fees.

54. VS Transition Strategy (2/96)

Reynolds, Jack. *"USAID-BKKBN Transition Strategy: Voluntary Sterilization and PKMI. A Draft for USAID Review."* University Research Corporation. Jakarta, February 1996.

Topic of study: **VS, PKMI, Costs, Sustainability**	Language of original report: **English**
Type study: **Analysis**	Location of report: **USAID**
Duration of study: **January 1996**	File name of report: **VS_TRAN**
Location of study: **National**	Date of report: **February 6, 1996**
Study Director: **Jack Reynolds**	Funding: **PSFP**
Technical assistance: **NA**	Summary prepared by: **Jack Reynolds**

Summary

This paper was prepared as a draft transition strategy for VS and PKMI. It summarizes findings and recommendations from a number of reports on VS and PKMI, identifies a number of transition issues that need to be addressed, proposes a transition objective for VS as well as a number of specific transition activities. The paper also identifies several implementation issues and recommends indicators for monitoring and assessing the proposed transition activities.

Current Situation

Government policy, which does not permit overt promotion of VS, is unlikely to change in the foreseeable future. Demand for VS has remained low for years due to a lack of awareness of the method and misconceptions about the operation and its side effects. Demand is not likely to increase, and GOI targets for the next five years reflect that. BKKBN and USAID have concentrated on improving the service delivery system. The current system is extensive (4,000 clinics) but underutilized (63% perform less than one operation per month). Cost is often cited as an obstacle to VS, but recent studies have shown that this is not the case. Private sector patients are willing and able to pay for the service. Adjustments to the BKKBN subsidy could be made so that all of the very poor could be completely subsidized. In the long run the Indonesian Managed Care system (JPKM) may become the most attractive mechanism for financing of VS. Support services, provided largely by PKMI, are expensive (Rp 6.1 billion for 1995-1996) and have been completely funded by USAID up until now.

Transition Issues

Even though VS is not likely to be incorporated into the national family planning program, it is important that the GOI policy toward VS services and support of PKMI be clarified. Without a formal statement and commitment, both are likely to atrophy rapidly. It is also time to accept that nothing significant will be done to create demand and that the extensive service system will need to be downsized. BKKBN and PKMI in particular, need to develop short and long-term financing strategies for VS and PKMI.

Transition Objectives and Activities

Given the constraints mentioned above, the proposed transition objective is to ***institutionalize a VS service and support system that can be maintained by the GOI.***

Three principal activities will be carried out over the next two-three years to assist the GOI to achieve this objective:

1. **Policy Development.** Assist BKKBN to formulate as specific a policy as possible in the next two years with respect to GOI support for VS services and PKMI. This policy would specify the roles of BKKBN, PKMI and other organizations in the provision of VS direct and support services, and identify short and long-term financing sources to ensure the long-term sustainability of these services.

2. **Transfer of VS Functions.** Assist BKKBN in the next two years to transfer such routine PKMI VS activities as training, quality assurance and equipment maintenance to other GOI-supported organizations. See the Appendix for a complete list of PKMI support activities.

3. **Model Development.** With BKKBN, PKMI, POGI and others, develop, test and evaluate in the next two years a downsized VS service system in one or more SDES-supported provinces. This model system would include the full range of direct and support services, including medical training, quality assurance, financing, and equipment.

Implementation Issues

USAID funding is coming to an end and technical assistance will also be ending soon. Therefore, action needs to be taken immediately to complete the above activities within the next 2-3 years.

APPENDIXES

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The bibliography is arranged alphabetically, according to author. The number in parenthesis at the end of each entry identifies the order of the study in the summaries section. Also see the Index to identify topics, study sites and types of studies that might be of interest.

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